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Clinical Lectures.

CLINICAL REPORT OF CYSTECTOMY FOR POLYCYSTIC OVARIAN TUMOR.

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Reported by J. G. Wiltshire, M. D., of Baltimore.

Gentlemen:—I bring before the clinic for examination to-day the case of Miss A., white, aged 21, single. She menstruated first at seventeen and was always regular in her habit, having a moderate flow lasting four days with but little pain up to her last period, Sept. 1st, 1891. Since then in place of menstruation, she has had a somewhat offensive leucorrhœa. She has been sent to me for treatment by Dr. S. Birnie, of Taneytown, Pa., and Dr. Simpson, of Harney, Md. About Jan. 1st, 1892, two months ago, her physicians had their attention called to a supposed tumor in her left iliac region, although she had noticed some enlargement in November. The abdomen grew rapidly, with sharp pains at first, until it attained its present large proportions. She says that she was feverish at first as it was growing; emaciation of the body kept pace in inverse proportion with this growth of the tumor and the increasing girth of the abdomen.

She now comes before you for a critical examination under ether. The note tells us further that her bowels are regular and there is no urinary trouble. She has never had any serious illness, and her family history is negative. Upon making a general inspection you will observe at once that her face is anæmic, thin, haggard, and drawn, bearing evidences of profound nutritive disturbance, there is also a peculiar pallor of a greenish yellow cast—a species of cachexia, suggestive at first sight of malignant disease lurking in some part of the body. Her expression, however, is more that which has been termed *facies ovariana*, the emaciation indicative of advanced ovarian disease. The pulse is slow and feeble. The respiration as you see is superior-costal, owing to the compression made upon the alate lower chest by the swelled abdomen.

Closer examination reveals no disease of the chest. There is no œdema anywhere.

Upon inspecting the abdomen, we find it greatly distended, ovoid in form, remarkably smooth on its surface, somewhat larger on the left than on the right side. The umbilicus is pressed out even with the surface, and is distant 21 cm. from the symphysis, and the same from the ensiform cartilage. When there is much free fluid in an abdomen as large as this the umbilicus is prone to be elevated much above the surface forming a slight hernia. We thus record in passing, a point against this tumor being an ascitic accumulation.

Observe closely and you will catch sight of a peculiar little wave constantly playing over the surface; this is not respiratory, it is cardiac in its rhythm, aortic in time; it is an important sign tending to show that something more or less tense or solid rests directly upon the aorta, filling up the space between the aorta and the anterior abdominal wall, for only in this way could the aortic pulsation be so clearly transmitted. It is really a percussion wave from behind. This also tends to demonstrate that the enlargement in our patient is not free fluid, but is either solid or enclosed in a tense sac.

Percussion reveals a corona of high pitched resonance over the upper surface of the tumor which I thus outline with an aniline pencil. The line thus made you

see is curved, lying just below and parallel to the ribs, with its convexity turned up, and its concavity looking towards the symphysis pubis. I first introduced this graphic method of demonstrating and studying various intra-abdominal and intra-thoracic diseases ten years ago when a resident at the Episcopal Hospital, Philadelphia, and have found it of great value, particularly when left on four or five days, in mapping out effusions or swellings which may change their outline from day to day. As I now proceed to percuss over the tumor (?) and on all sides, you note that while the vaulted prominence itself is absolutely flat, it is surrounded on three sides, the upper and the two lateral, above and in both groins, by a peculiar tympanitic note belonging to the colon. The whole inferior zone however on the pelvic side, is again absolutely flat.

Fig. 1.—Patient on the operating table. A side view of a smaller ovarian cyst, weighing twelve or fifteen pounds, showing its characteristic contour, not unlike that of a uterus in the seventh or eighth month of pregnancy.

This peculiar circumscription in an area of dullness, having its base or point of origin as it were below, indicates a more or less coherent foreign mass in the abdominal cavity; the continuance of the dull percussion note downwards without the intervention of any area of tympany as

above, indicates an organic connection with the pelvic organs and at once suggests the pelvic origin of a tumor.

Aside from this direct evidence that we are thus dealing with a pelvic tumor, we we will make our demonstration clearer if we also seek evidence by exclusion, that is by an area of peculiar tympanitic dullness. What can it be? By continuing the percussion over towards the right hypochondrium you observe that this note gradually shades off step by step by the finest gradations of sound into the absolute dullness of the liver, showing by this continuity that the

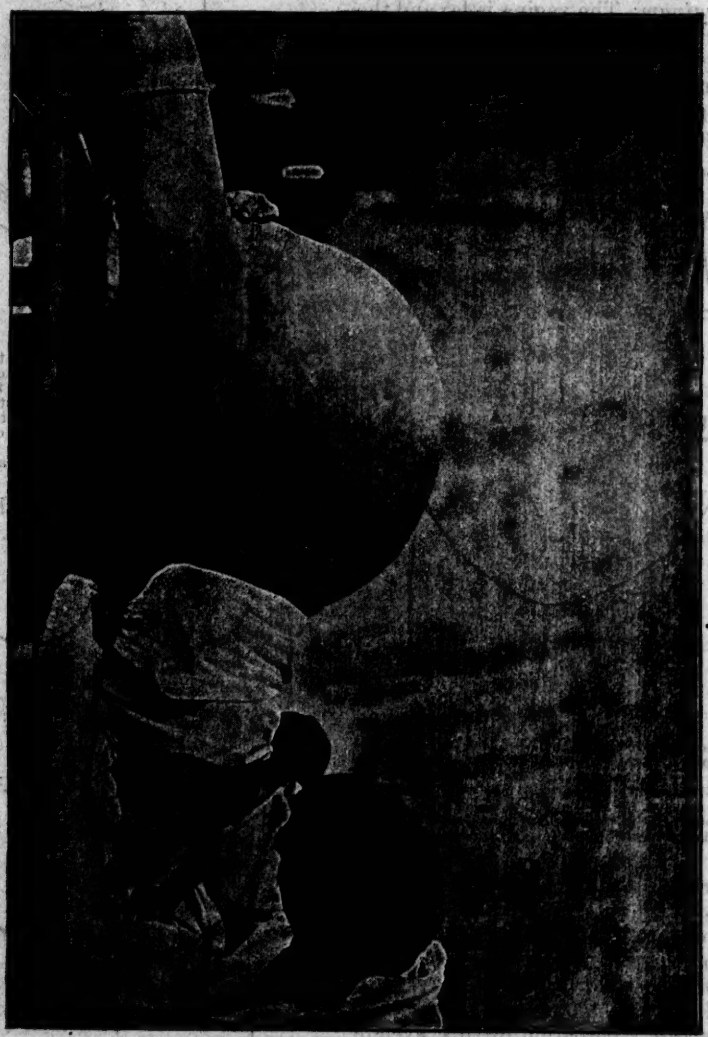

Fig. 2.—The photographic side view of a similar large ovarian cyst, showing the marked spherical distension of the abdomen due to the presence of a large sac distended with fluid.

percussing out the various important solid viscera, when if we find them all "at home" so to speak, we will feel more than ever assured as to the pelvic origin of our tumor.

You now note above the tympanitic zone, in the median line my strokes demonstrate "tympanitic dull" area marks the location of the left lobe of the liver.

The spleen also is easily demonstrated near its normal site, and the tympanitic flanks exclude the kidneys from participation in the disease.

We thus again by exclusion reach the

conclusion that this is a pelvic tumor and the area of resonance surrounding it is the *corona uterina* or *ovariana* characteristic of a uterine or ovarian tumor.

Palpation shows that we are dealing with a homogeneous fluctuating mass, with no bosses or irregularities on its abdominal surface.

Per vaginam: The vagina is lax and the small cervix depressed towards the pelvic floor; the pelvis is distended with an elastic cyst filling the retro-uterine pouch, fuller on the right side. The pelvic organs are thus displaced downwards on the floor by

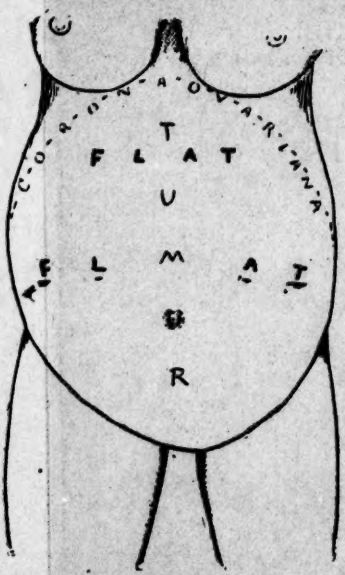

Fig. 3. The distended ovoid belly of the patient. The tumor occupies about all the small circular area outlined. Above is the *corona ovariana*, here the tympanitic note of the displaced intestines appears distinctly on percussion. The areas marked "Flat" occupy the whole of the abdomen below the *corona*, and demonstrate the presence of the large tumor immediately beneath the abdominal walls.

the superincumbent weight of the tumor. The body of the uterus is anteflexed and tilted over into the left flank, and rests upon Poupart's ligament. I feel also a small boss posteriorly which may be a displaced ovary.

Per rectum: Palpation by this avenue further confirms the diagnosis which is forming as to the character of the tumor.

We have to deal with a cystic, ovarian tumor, of rapid growth probably of an adenoid or papillary nature. Its point of departure is from the left broad ligament as shown by the fact that the uterus is drawn over to the left side. In small tumors a reverse displacement is the rule. This appears also to be either a mono-

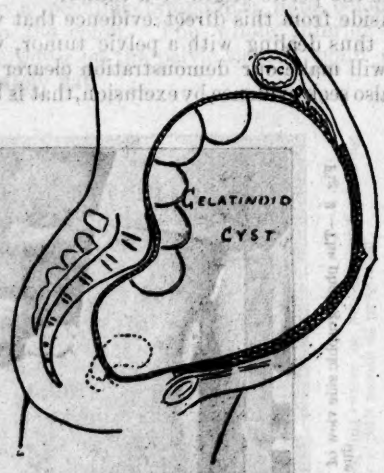

Fig. 4.—A sagittal section through the tumor described in the paper. "T. C." is the transverse colon above, immediately below this "o" the omentum, is intimately adherent to the cyst wall. From the omentum down to the symphysis the cyst is seen to be adherent to the anterior abdominal wall. In the posterior part of the cyst are seen a number of small daughter cysts. The uterus is seen outlined low down in the pelvis and anteflexed.

cystic tumor or a tumor with one large and a number of smaller cysts.

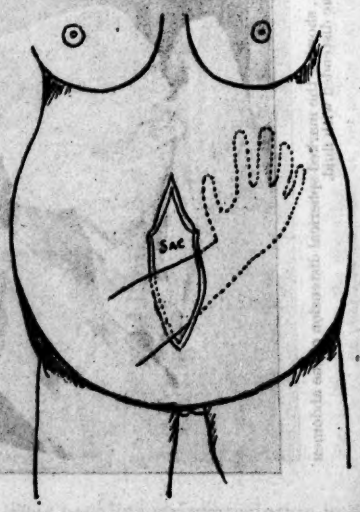

Fig. 5.—The incision extending through the umbilicus. The sac is seen through the gaping edges of the incision. The right hand of the operator is introduced between the sac wall and the parietal peritoneum, by opening and closing the fingers and pushing the hand along the tumor is being stripped loose from its adhesions.

Monocysts in general are of two kinds, *ovarian* and *parovarian*. The latter o

slower growth, contain a limpid fluid and if tapped or accidentally ruptured the fluid sometimes does not re-accumulate, in this simple way establishing a cure.

Fig. 3.—Grouping at an operation. The operator, his chief assistant, the anæsthetiser, and some visitors grouped about the operating table. A small ovarian tumor is being lifted out of the abdominal incision, which the assistant is holding open with a retractor, while the operator is engaged in transfixing the pedicle preparatory to ligation and removal.

The ovarian cases spring from the base or stroma of the ovary, and often contain adenoid and papillary masses, growing rapidly and evincing their malignant nature by the general effect on the nutrition as well as by an overgrowth on the surrounding tissues. Their rapid growth is often accompanied by a most marked cachexia. This may be a tumor of this class.

Nothing, however, but the operation itself—cœliotomy—can settle this finer

question positively, to the advantage or disadvantage of the patient.

OPERATION, Monday, February 29th, 1892, under ether anæsthesia. The bowels had been regulated, the diet restricted, and the urine carefully examined, and the abdomen prepared by daily washings in the ward. It was again, however, thoroughly cleaned on the operating table with soap and water, ether and alcohol. The field of operation was then covered with a wide piece of aseptic gauze, and sterilized towels laid above and below the chest and thighs. A slit in the gauze exposed that portion of the abdomen which was to be opened for the removal of the tumor. An incision 10 cm. in length [4 in.] was made in the median line below the umbilicus, disclosing at once the glistening wall of a large ovarian tumor. On attempting to tap the tumor no fluid flowed. The cyst was filled with a tenacious gelatinoid mass. It was therefore necessary to enlarge the incision until it extended above the umbilicus. The wall of the tumor being everywhere adherent to the abdominal wall, these adhesions were rapidly broken up by passing the hand in between the cyst and the abdominal wall, using the fingers with a shearing movement. A large part of the omentum which was closely adherent to the tumor was removed and its vessels controlled by six ligatures. The tumor was then lifted out of the abdomen *en masse*. Its pedicle sprung from the left side where it was very broad, requiring eight ligatures to tie it off.

The abdomen was thoroughly washed out with 4 litres [4 quarts] of normal salt solution. An actively bleeding area on the anterior abdominal wall was controlled by a circular suture introduced all around the margin and drawn tight and tied. The right ovary and tube were free from disease.

After removing all water from the abdomen the incision was closed without drainage. A continuous suture of catgut was used to unite the divided peritoneum, and silk-worm gut to bring together the skin, muscles and fascia. The duration of the operation was a half hour.

CONVALESCENCE was rapid and satisfactory. The temperature went up to 100½° on the second day, and varied from 98° to 100° up to the tenth day. The pulse after the first day ranged between 84 and 96, but with an elevation of temperature to 101° on the tenth day due to suppuration in the incision the pulse also went up to 112.

A slight stitch-hole abscess was noticed on the seventh day, from this pure cultures of staphylococcus aureus were obtained.

On the twentieth day a marked induration was noticed around the lower part of the wound, followed immediately by a free discharge of pus. This was entirely healed in six days.

A letter from her physician received more than two months after the operation states that she is perfectly well, and occupied in doing light house work.

[I have felt an interest in reporting this case, as exhibiting the simple and satisfactory technique of these operations at the Johns Hopkins Hospital, the operation being one of a long series I have witnessed there from week to week for two years past.—J. G. W.]

CINNAMIC ACID IN SURGICAL TUBERCULOSIS.

Dr. A. Landerer has employed this remedy in 45 cases, of which 31 were cured, 7 improved, 1 unrelieved, 2 died, and 4 were still under treatment at the time of the report. In cases of tubercular arthritis an emulsion of cinnamic acid was injected into the joints, the following formula being employed:

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Acid cinnamic	5.0
Ol. amygdal	10.0
Vitelli ovi unius	
Sol. sodii chlorid (0.7 per cent.)	
q. s. ut fiat emulsio	100.0

The cinnamic acid is first rubbed fine with the oil, then the fresh yolk of one egg is added, after these have been mixed together the salt solution is added in drops. The resulting emulsion has a strongly acid reaction, which before it is used must be neutralized by addition of a 25 per cent. solution of potassium hydrate. About 5 c. cm. is deeply injected and the injection repeated twice a week. In cases of fistulous processes a solution of cinnamic acid in alcohol (1 to 20) was injected into the surrounding tissue. If this was insufficient the foci were laid bare, curetted and tamponed with balsam of Peru gauze, or cauterized with cinnamic acid in alcohol. Frequent irrigation of wound cavities with the latter or with Peru balsam was also found of value.—*Wein. Medizin Presse*, No. 11, 1892.

SURGERY OF THE GALL-PASSAGES AND LIVER.

By DR. W. KÖRTE,
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(*Continued from the last issue of the* REPORTER.)

Cholecystotomy with subsequent suture or cholecystendysis, as it has been called by Courvoisier, the father of the operation, has usually been designated as "ideal" but "dangerous." The danger feared was the possible bursting of the suture, but numerous cases have shown that this danger does not exist, that is when suitable cases for the performance of the suture have been chosen. The choledochus must be free and the walls of the gall-bladder strong. For this reason also, I have hesitated in performing the suture in cases of empyæma of the gall-bladder. According to Voight's report in the *Deutsche Medicinische Wochenschrift*, Heusner has made his suture in thirteen cases with entirely satisfactory results.

The great advantage of the operation lies in the fact that by means of it a more rapid complete healing—and therefore cure—can be obtained than by any other method, since biliary fistulæ, which are so unpleasant, are avoided thereby. Apart from the great discomfort caused to the patient by the constant discharge of bile from these fistulæ, the loss of bile entailed is by no means an immaterial one. In some cases that have come under my notice from 300 to 700 grammes of the fluid have been absorbed by the dressings. It seems that some persons bear well the loss of bile, while it affects others most unfavorably. These latter patients will become greatly emaciated in spite of the maintenance of a rich, nourishing diet.

An advantage of the gall-bladder suture, besides that of doing away with the possibility of fistula, is the fact that the abdominal wound may at once be closed, all but a small opening for the strip of iodoform gauze. In this way the ultimate probabilities of abdominal hernia are not nearly so great as when the gall-bladder is stitched to the abdominal wall. Again, when the incision is made parallel to the edge of the ribs, the possibilities of subsequent hernia are materially lessened in my estimation. The scar is close to the thorax and the liver lies behind it, and in this way the intestines do not exert any material pressure upon the scar tissue. Moreover, in women the corset acts as a compressing bandage and removes the pressure upon the wound.

In the majority of cases of simple concremental formations in the gall-bladder, and of occlusion of the ductus cysticus by stones, with subsequent dropsy of the gall-bladder, I consider cholecystotomy with subsequent suture and replacing of the gall-bladder as the best procedure. In such cases I would never contemplate the extirpation of the gall-bladder, although the procedure may be attended by good results when performed skillfully—this fact is demonstrated by Langenbuch's results. Nevertheless, I do not consider Langenbuch's reasons for the performance of the operation as well founded. In four autopsies performed in cases of gall-stone I have found small concremental formations in the liver itself, while Langenbuch boldly asserts that these stones can only be formed within the gall-bladder, and that the removal of the latter removes also their source of formation. My own experiences are however, also upheld by such authorities as Weigert, Sendler, Thornton, and Courvoisier, and possibly also by Braun and Buchanan, who have also found concremental formations in the liver itself.

If after the operation of cholecystotomy concremental formations again subsequently make their appearance in the gall-bladder, a second operation would be accompanied by no greater difficulties than the first, similarly as in a relapse in cases of stone in the bladder. This possibility of a recurrence of the trouble, would not, however, offer any inducement to me regarding the advisability of an extirpation of the gall-bladder. It seems also to me to be an unspoken law of conservative medicine—or rather surgery—that an organ which can be retained with justice should not be removed—and the utility of the gall-bladder cannot be denied. Finally, I must not forget to add, that the extirpation of the gall-bladder is an operation of far greater technical difficulties than its opening and subsequent suture. I would reserve the operation of cholecystotomy for performance only in such cases in which the walls of the gall-bladder are of such a nature as not to warrant the immediate suture.

In five cases of dropsy of the gall-bladder (hydrops) (Cases I to V) stones were found ranging in size from that of a pigeon's egg to the size of a cherry. Usually several stones were found in each case, and in one case several small ones as well (Case V). In Case IV, a stone as large as a pigeon's egg was found that closed the cystic duct. Out of the six patients operated upon for enlargement of the gall-bladder, in only one were no stones found. This patient (Case VI) was sent to me by her physician, Dr. Walsten, having been suffering for nine months with the most severe vomiting of all foods, as well as cardialgia. The gall-bladder was enlarged and easily felt, and yet when I opened it I only found a large quantity of gall, but no stone; neither could any concremental formations be found in the bile ducts. The pylorus and stomach were found normal. The liver, however, did not appear entirely normal. After the gall-bladder was closed it was fastened to the peritoneum at the edge of the ribs with a few buried sutures. The condition of the patient improved wonderfully. She had no pain and could eat heartily. After her return home, however, the old symptoms gradually returned.

In one case, my diagnosis wavered between that of gall-stone and of a malignant growth of the liver. An exploratory incision was made and a carcinoma of the liver found (Case VII).

In the four cases of empyæma of the gall-bladder, serious conditions were present in all. In the least serious case the gall-bladder had grown fast to the abdominal wall, and the suppuration had extended into the latter (Case VIII). In this case there was no stone and the cystic duct was obliterated. Another patient besides suffering both from suppuration and stone in the gall-bladder, had consecutive suppuration of the gall-ducts in the liver, and carcinoma of the pancreas as well. It is almost needless to say that this case had a lethal ending. In the third case suppuration in the liver and in the subphrenic space occurred as consequent to the empyæma of the gall-bladder. After many operations these various foci of suppura- were found and successfully treated (Case IX), finally an occlusion, of the choledochus also occurred, and this was also successfully treated. The fourth patient (Case X) applied for treatment when already suffering from symptoms of septic poisoning. At the operation the outer surface of the gall-bladder was seen to be discolored being yellow in portions. Three large die shaped stones were removed, the mucous membrane was found to be partly necrotic. It will be seen that the patient was operated upon just in the nick of time to save her from complications which soon must have terminated fatally, or at least as soon as the suppuration extended to the abdominal cavity. Even after the operation there were very threatening symptoms which pointed towards suppuration of the liver, but these fortunately abated after a time. The necrotic parts of the mucous membrane of the gall-bladder sloughed off. From the pus found in the gall-bladder, pure cultures of the *bacterium coli commune* were found—this is as Naunyn has also observed.

In all cases, empyæma of the gall-bladder proved itself to be a most dangerous disease, accompanied by most grave effects. The operation consisted in an opening of the gall-bladder and stitching it fast to the abdominal wall. In two cases the gall-bladder had already formed adhesions to the abdominal wall, prior to the operation in consequence of the inflammatory process. In these cases the operation was, therefore, considerably simplified.

The severest symptoms manifested by any disease of the gall-duct system, were seen in cases of occlusion of common gall-ducts. This is usually occasioned by stone, but less frequently by the formation of cicatrices, or by tumors that exert a pressure from without the gall-bladder. The great dangers of this condition are very palpable and well-known. The secretion from the liver is prevented from entering the digestive system, on the one hand, and the bile is forced in the circulation, giving rise to cholæmia. The fact that we can relieve this condition by the use of the knife, can rightfully be regarded as a triumph of surgery. It has been the ingenius propositions of von Winiwarter that first shed light upon this important subject. He taught that if a communication were re-established between the gall-bladder and the intestine, that the gall would again be absorbed by the digestive system. In other words, he was the first both to suggest and perform the operation of cholecystoënterotomy. His successful operations have been repeated also by other

surgeons.* In connection with Winiwarter's operation Sprengel also succeeded in establishing an anastomosis between the enlarged ductus choledochus and duodenum.† While this operation gets around the occlusion of the gall-duct by the creation of a connection with the intestine it also acts directly upon the occlusion by stone, of the choledochus. The stone has been crushed in the gall-passage and débris pushed into the intestine (Langenbuch, Kocher, Credé) and finally the stone has been cut out of the exposed ductus choledochus and the wound sewed up (Heusner, Küster, Courvoisier) and with good results.

Frankly, those operative methods which deal directly with the cause of the occlusion —the gall-stones—are preferable in such cases in which a removable of the occlusive cause is of principal importance. If the occlusion be caused either by cicatrices or tumor, the creation of a gallic-intestinal fistula is the only rational procedure; this is equally true when sufficient exposure of this ductus choledochus is impossible. This last complication was present in three cases in which I operated for occlusion of the choledochus from stone. In the operations referred to, I had it in my mind to lay bare the ductus choledochus, and so I worked down through dense adhesions at the under surface of the liver, as deeply as possible, in order to search for stone; but I neither was able to find a stone (although in two cases the autopsy revealed them), nor even positive of having found the choledochus from amidst the cicatrical tissues. I therefore, in the first two cases (cases XII and XIII) established a gallic-fistula in order to prevent cholæmia, and, indeed, in two separate operations. This for the reason that in the one case (XII) the shrunken gall-bladder was difficult to apply a suture to, and in the second because the the gall itself was decomposed, and I therefore considered the dual operation safer. After the first operation the first patient showed a marked improvement of the cholæmic symptoms, but lost considerably in consequence of the loss of gall, and refused to submit to the second operation until too late. Therefore, the establishment of the gallic-intestinal fistula was not undertaken, the patient being too far gone. If it had been possible to complete this operation within a reasonable time, or possibly at the one sitting, the patient's life perhaps might have been saved. (This was the first case of any operation upon the gallic-system.) The second patient came with severe septic symptoms in consequence of diffuse suppuration of the liver and gall-passages, and died from septic poisoning. Here any procedure would have come too late to be of any avail. Neither of the patients succumbed from the effects of the operation but from their original trouble. It was interesting to me to note, that even at the autopsy, when entering the abdominal cavity through the wound made by this operation no stone or obstruction could be found. Not until both the stomach and liver had been removed, and the ductus choledochus carefully examined from the intestine on, was I able to find in the duct, close to the opening of the cystic duct, and wedged in, a stone of the size of a hazlenut. One of these stones was easily crushed with the fingers, but the other was quite hard.

In the third case an occlusion of the choledochus developed while the case was under my observation, the case being primarily one of suppuration of the gall-bladder, liver, and subphrenic space (Case XI). The patient after having shown total scholia in the fæces for four weeks, was operated upon. I was, however, unable to lay bare the choledochus, and it remained uncertain as to whether the obstruction was caused by stone or cicatrical stenosis, the indications, however, were in favor of the latter diagnosis. Finding myself completely thwarted in my endeavors to lay bare the gall-passages, I quickly determined to establish an anastomosis between the gall-bladder and the duodenum. I therefore sewed the gall-bladder to the bowel, opened both organs and then stitched the edges of the cuts together. The act of applying a suture so deep in the abdominal cavity, constituted not only a difficult but most tedious undertaking. For the sake of precaution, I wound a strip of iodoform gauze around the suture, and kept part of the abdominal wound open. The suture uniting the gall-bladder and intestine healed well, however, and the gall began to flow into the intestine. No gall was ever discharged through

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* See *A. Courvoisier, Chirurgie und Pathologie der Gallenwege.*

† See *v. Langenbeck's Archives*, 42-3.

the wound. The result of the operation was truly excellent; the patient recovered rapidly, and only the sloughing out of a few silk sutures gave rise to some slight difficulties. This is the second case of cholecysto-duodenostomy that was ever performed, the first operation of the kind having been performed by Terrier.*

Rupture of the gall-stone into the abdominal cavity only occurred once in my experience. The patient was an old lady, who had suffered intensely with gall-stone colic, and the rupture occurred during one of the attacks of colic. In similar cases Küster has operated, but without being able to prevent the development of peritonitis. Rupture of the gall-stone into the intestine with subsequent ileus, I have seen in three different cases.† Two of these patients were operated upon and the one recovered, while the third patient died without operation. In the two cases that died, the autopsy revealed the perforation of the gall-bladder into the duodenum. Licherstern, Courvoisier, and Treves report several similar cases.

I will now briefly give the histories of the patients upon whose cases the foregoing remarks have been based.

Cholelithiasis; dropsy of the gall-bladder; cholecystotomy; plastic closure of the fistula; recovery.

Case I. Mrs. E., thirty-eight years old. The patient had been married for sixteen years and had borne two children, the youngest being eleven years old. For eight years she had been troubled with pains in the region of the liver, growing worse always during menstruation. Latterly she also complained of simultaneous "stomach cramps" and back-ache. Bowels sluggish, but fæces not decolorized. During the attacks the color of the face was slightly yellow.

The patient was admitted to the hospital July 2, 1890. She was well nourished. Skin slightly yellow. The liver stretched beyond the curve of the ribs to the width of two fingers. The gall-bladder could be easily felt as a semi-spherical tumor, and was painful to the touch. Urine free from gallic coloring matter. Fæces normal.

The patient was kept under observation several weeks, The size of the gall-bladder was seen to vary. All the symptoms were aggravated during menstruation. July 30, 1890.—Cholecystotomy was performed at one sitting. Longitudinal incision over the tumor; partial evacuation of the contents of the gall-bladder by puncture. The gall-bladder then stitched to the abdominal wound, and opened. A light colored shiny fluid was evacuated, two stones as large as pigeon eggs removed with forceps. The case proceeded well, and there was a large secretion of gall. On September 3 and 13, the fistula was burnt with the Paquelin cautery. On September 23, the gall-badder was closed by a union of the incision in it with a row of sutures. The abdominal cavity was then closed, and healed by first intention. The patient was discharged November 21.

During the beginning of April she again came under treatment, being in perfect health but having an abdominal hernia.

Discharged November 16 1891 as completely cured.

Cholelithiasis; dropsy of the gall-bladder; stone wedged in the cystic duct; cholecystotomy; suture and sinking of gall-bladder; recovery.

Case II. Anna V., 23 years old; working woman.

On October 31, 1890, the woman suffered from an abortion, and the subsequent uterine hæmorrhage lasted for 15 days, and was only checked by the use of the curette. Since then the patient had suffered from pain in the region of the liver.

Admitted November 29, 1890.

Uterus enlarged, flabby, and discharging blood.

Curetted and iodine injected.

Gall-bladder palpable as a round tumor.

Liver not enlarged. The gall-bladder painful as well as painful to the touch. No icterus.

December 13, 1890. Cholecystotomy performed. Longitudinal incision, gall-bladder drawn forward and packed around with gauze, then incised and about 50 cubic centimeters of a viscid yellowish fluid evacuated, and two stones the size of cherries, removed from the opening of the ductus cysticus.

Gall-bladder closed with two rows of

*See Courvoisier's work on the subject.

†These have been described in my work on *Ileus, Berliner Klinik*, No. 36, pages 14 to 17.

sutures and stitched to the peritoneum of the edge of the wound. The abdomen closed until over the region of the gall-bladder suture, but subsequently—after the lapse of four days, when the stitches supporting the gall-bladder had been loosened—entirely closed. Healing by first intention.

January 13, 1891, discharged as cured. The patient was subsequently seen again after the lapse of several months, and was found to be perfectly well. There was no abdominal hernia in this case.

Cholelithiasis; dropsy of the gall-bladder; stone wedged in the cystic duct; Cholecystotomy; suture and subsequent sinking of the gall-bladder; recovery.

Case III. Mrs. L., 33 years old. Had borne many children. Had suffered for the last five years with pain in the upper abdominal region; and for several months back had had periodical attacks of colic. She had never been jaundiced. Bowels sluggish. Admitted January 6, 1891. Gall-bladder enlarged, and easily palpable under the margin of the ribs as a roundish tumor. Moderately painful to the touch. No icterus.

January 12, 1891. Cholecystotomy. Longitudinal incision. Mesentery adherent to the gall-bladder. Adhesions loosened, the gall-bladder drawn forward, and surrounded with gauze. The incision allowed the evacuation of a quantity of a light yellow, slimy fluid, and a stone the size of a huckle-berry. A second stone was found wedged in the ductus cysticus, and after many futile efforts at extraction, was easily removed by the fingers, these being inserted into the abdominal cavity, under the duct. Suture applied in two rows to the gall-bladder. Abdominal wound closed to all but two sutures, which were also closed on the fourth day. Absolutely normal course of wound. Patient discharged as cured February 9.

Cholelithiasis; dropsy of the gall-bladder; gall-stone colics; stone wedged in the cystic duct; cholecystotomy; suture and subsequent sinking of the gall-bladder; recovery.

Case IV. Mrs. S., 33 years old. Had borne several children, the last only four years previously. In the year of 1880 she had catarrh of the bladder, and retention of urine, caused by an ovarian tumor. On November 19, 1890, double ovariotomy was performed upon her in the Urban Hospital. After her child-birth in the year of 1882, colicky pains appeared in the right side of the abdomen, which were characterized by the patient as "stomach cramps." During the last pregnancy these attacks became more frequent and severe, especially after eating, and from time to time the skin assumed a slightly yellow color. On August 18, 1891, she had an unusually severe attack, and the gall-bladder was found to be enlarged.

On August 22, 1891, she was admitted to the hospital. The patient was seen to be of delicate constitution and the color of the skin slightly yellow. Below the margin of the ribs on the right side, the gall-bladder could be palpated as a round, hard and very sensitive tumor. The urine was normal and contained no gallic coloring matter.

August 24, 1891. Cholecystotomy performed. Longitudinal incision from the margin of the ribs down for 8 centimetres; and situated directly over the tumor. The gall-bladder which was found to be as large as a hen's egg, was drawn forward and bedded in gauze. Forty or fifty cubic centimetres of light gall with flakes evacuated. A stone could be felt by the finger to be imbedded, or rather wedged, in the ductus cysticus, and was removed not without considerable difficulty with a blunt hook. Gall-bladder closed with a single row of sutures. Abdominal wound closed, but a strip of iodoform gauze left between two sutures, as a drain, which was removed on the fifth day. Subsequent course without fever, but during the first few days still pain in the gall-bladder. A few weeks after her discharge some of the sutures sloughed away.

She reported November 16, 1891, as perfectly well.

Cholelithiasis; frequent gall-stone colics with icterus, and temporary occlusion of the gall-bladder; cholecystotomy; suture, and subsequent sinking of gall-bladder; passing discharge of gall; recovery.

Case V. Mrs. G., 31 years old. The patient had borne six children. Four months after the last child-birth gall-stone colics with icterus appeared (July, 1890). During the May of 1891 the severe gall-stone colics again appeared. She was admitted October 25, 1891, with a most

severe attack. Icterus appeared, and the fæces became clay-colored. On October 30, gall was again present in the fæces. During this time the gall-bladder could easily be felt as a tumor about the size of a hen's egg, just below the margin of the ribs. It was very sensitive to the touch, and this sensitiveness did not abate even after the attack had passed. After the stools had been normally colored for six days, and the icterus had disappeared, the operation of "ideal cholecystotomy" was performed on November 6, 1891, with a transverse incision along the margin of the ribs. The gall-bladder was found to contain viscid slime and many stones, the most of which of a pyramidal form with a four-sided base. The cystic duct was stuffed full of stones which were removed with the hook. In the ductus choledochus nothing was found by palpation even from the abdominal cavity. Sounding the latter was attempted, but found impossible. Suture of the gall-bladder with two rows of catgut sutures. Iodoform gauze laid over the suture. Normal course of recovery with the seventh day, and then some gall was drained out through the strips of iodoform gauze. This discontinued on the tenth day. The wound was entirely healed on November 27, 1891.

Severe cardalgia. Vomiting; enlargement of the gall-bladder; existence of gall-stone accepted; cholecystotomy; no gall-stone found; suture, and subsequent sinking of the gall-bladder. Healing of the wound; subsequent return of the cardalgia in four weeks (hysteria.)

Case VI. Mrs. G., 40 years old. Attending physician, Dr. Wulsten. Since July, 1890, the patient had severe pains in the back and abdomen, accompanied by nutritive disturbances. In November, 1890, a large subserous myoma and both ovaries were removed. The pains in the abdomen continued and concentrated themselves in the region of the stomach. They became most intense and morphine was required to afford any relief. Nutrition became greatly impaired owing to the constant vomiting; the patient became very much emaciated, losing seventy-five pounds in the course of a few months. In May, 1891, an examination was made while the patient was under the influence of an anæsthetic. A round, hard tumor could be felt in the region of the gall-bladder, and besides this, a floating kidney in the right side.

Diagnosis: Possible dropsy of the gall-bladder, with incarcerated stone in the cystic duct.

Laparotomy was performed on May 21, 1891. Incision parallel with the border of the ribs. Gall-bladder enlarged but not adherent. No stone could be felt. The liver and gall-bladder were drawn forward. The gall-bladder incised and a viscid dark green gall evacuated. Digital examination failed to reveal any stone; the gall-bladder then closed with two rows of sutures. The pylorus drawn forward, but found normal. Examination of the neighboring viscera negative. The very loose attachments of the lower lobe of the liver were reenforced by three silk sutures to the edge of the ribs. The abdominal wound closed, and the subsequent course of recovery from the operation entirely normal.

The pains ceased entirely, and the patient took and retained plenty of nourishment and increased in strength. She was discharged on August 18.

In spite of the negative result of the operation the primary beneficial change of the patient gave hopes of an ultimate complete recovery, but no sooner had the patient returned home, than the old symptoms again became manifest. Her present condition is, according to the statement of her physician, as bad as it ever was.

Carcinoma hepatis, mistaken for gall-bladder tumor; exploratory incision.

Case VII. Mrs. S., sixty years old. Until six weeks prior to admission the patient had never suffered from any symptoms of gall-stone. She became ill during the first of May with severe periodical pains in the region of the liver, and simultaneously a gradually increasing tumor became manifest, which from its form and location corresponded to a gall-bladder.

The patient was admitted on June 13, 1891.

Extending over the liver, on a perpendicular line with the nipple, and at the edge of the ribs a hard, rather flat, circular and sensitive enlargement could be felt, which was connected with the liver. No icterus, and no vomiting.

Diagnosis: While the finding was not at all typical the probabilities seemed to point to "retention-cyst" of the gall-

bladder, but the possibility of the growth being a malignant tumor was also recognized. On June 16, 1891, an exploratory incision was made, parallel with the curve of the ribs. The growth was found to be a tumor of the liver itself and very vascular. The gall-bladder, which was covered by the growth, was not enlarged. The abdominal wound was closed, but healing was delayed by phlegmons. The pains abated, but the tumor continued to grow. The patient was seen again in October; she had then ascites and knotty tumors in different parts of the abdomen. Death about the middle of November, 1891.

(*To be continued.*)

DRUNKENNESS AS A VIRTUE.

Dr. George Foy sends the following letter to the *London Medical Press*, of November 18, 1891:

"Sir,—As an evidence of the altered social habits of the general public, I wish to bring a curious old volume under the notice of your readers. It was printed for E. Curl, against Catharine Street, in the Strand, London, in 1723, and is marked "Price Five Shillings." The title is as follows: "Ebrietatis Ecomium, or the Praise of Drunkenness; wherein is authentically and most evidently proved the necessity of frequently getting drunk; and that the practice of getting drunk is most ancient, primitive, and catholic. Confirmed by the example of Heathens, Turks, Infidels, Primitive Christians, Saints, Popes, Bishops, Doctors, Philosophers, Poets, Freemasons, and other men of learning in all ages. By Boniface Oinophilus, de Monte Fiascone, A. B. C."

Vinum rectificans cor hominis,
Narratur et Prisci Catonis,
Sæpe mero caluisse virtus.
HORAT.

The author lays down the following rules for getting drunk, to wit:

1. Not too often.
2. In good company.
3. With good wine.
4. At convenient times.
5. Force no one to drink.
6. Do not push drunkenness too far.

The volume ends with a postscript by F. Sans-terre, dated May 1, 1723, "*From my Garret in* Bandy-legged Walk." A year made memorable by the death of "Vanessa."

Communications.

REPORT OF A FEW LAPAROTOMIES DONE IN THE ALLEGHENY GENERAL HOSPITAL BY R. STANSBURY SUTTON, M. D., GYNÆCOLOGIST TO THE HOSPITAL.

BY MARK A. RODGERS, M. D.

(*Continued from the issue of July 9, 1892.*)

Continuing the report of Laparotomies done at the Allegheny General Hospital from the issue of July 9th, of this journal, I beg leave to submit a second series of cases which I think will prove much more interesting to lovers of abdominal surgery than those of the first report.

CASE XI. Double salpingo-oöphorectomy. Diagnosis:—menstrual epilepsy, chronic salpingitis and ovaritis. Miss R., aged 24. History negative until puberty, at which time she developed menstrual epileptic convulsions of a severe enough type that she presented many scars on various parts of her person, from falls, burns, etc., received during seizures. She had given birth to a child two years previous to her admission, and during pregnancy had experienced an abatement of the epileptic symptoms, which returned with increased severity after the birth of the infant. On examination, there appeared a small bilateral laceration of the cervix, which, however, was occasioning her no discomfort, and a mass in Douglas' pouch immobile and excessively tender, which was thought to be a prolapsed ovary.

Operation June 7th, 1892. Both ovaries were prolapsed, much congested, enlarged and firmly adherent to uterus, rectum and *cul de sac*. Both were removed. Abdomen flushed and closed. Time, twenty minutes.

Had two seizures on sixth day, at which time temperature rose to 101·4°. Calomel and saline purge was followed by normal temperature. No seizures from that until present time. Patient made rapid recovery and is now in good health.

CASE XII. Cholecystotomy. Diagnosis, impacted gall-stones. Mrs. B.,

aged 45. History negative, save as to hepatic colic, which had been almost incessant for several years. On admission was deeply jaundiced and suffering great pain.

Operation June 10th, 1892. An incision three inches in length was made in the right hypochondriac region, exposing the gall-bladder and liver. The upper end of the incision began a short distance above the end of the tenth rib. The liver seemed congested and the gall-bladder was enormously distended. An aspirator was introduced into the latter and about one pint of muco-purulent material withdrawn. Numerous calculi could then be felt through the cyst wall. The bladder was next stitched to the peritoneum, the wound closed above and below, and finally the viscus incised. Seventy-two stones were removed, ranging in size from an English walnut to a small pea; two of the smaller were removed from the cystic duct and one extracted with great difficulty from the common duct. The instrument used for this purpose was a small uterine curette. Time, one hour.

Jaundice almost immediately disappeared. Patient had a severe attack of colic during fourth day. Otherwise convalescence was uninterrupted. Discharged June 29th, with slight biliary fistula which was rapidly closing by granulation. Patient at that time had good appetite and was in good state of general health.

Case XIII. Double salpingo-oöphorectomy. Diagnosis,—double pyosalpinx, with pelvic peritonitis. Mrs. B., aged 40. History negative as to difficulty under consideration, save a history of long continued and excessive pelvic pain and an indistinct history of amenorrhœa. During a sojourn of one week in the hospital, her temperature registered from 99½° to 101½°. On inspection and palpation, the abdomen was found to be enlarged especially on right side, and presented a diffused tumor-like mass, extending from the umbilicus. Bimanuel examination revealed uterus firmly fixed and semi-fluctuating masses encroaching upon the vaginal vault from both sides. This patient suffered intense agony and preferred death to her miserable condition.

Operation June 11, 1892. This was the most difficult case operated in this entire series of twenty-one cases. When the abdomen was opened the omentum was found adherent to the intestines; after its separation it was so bruised and lacerated that much of it required amputation. The intestines were agglutinated by dense connective tissue, and the whole fitting down over uterus and adnexa like a cowl. In attempting to separate the adhesions the tube on the left side was ruptured and fully a quart of virulent looking pus evacuated. A line of cleavage was attained and the tube which was converted into an abscess sac of prodigious size was with the left ovary finally tied off. The operator's attention was then turned to the right side. The intestines were raised and an enormous pus tube exposed to view. This was also found bound down by adhesions, but they yielded more easily to the operator's efforts than was expected, and after ligating several quite large vascular cords of connective tissue, the tube was finally delivered intact. It was ligated and removed. The abdomen was thoroughly flushed with about eight gallons of very hot water and closed. Time on the table 45 minutes.

There was some distension on the fourth day, which was relieved by turpentine enemata. Union occurred by first intention and the patient was discharged June 26, rapidly regaining health and strength. The fact that union took place without a drop of pus, is sufficient evidence in the operator's opinion that an abundant supply of hot water is adequate for purposes of thorough disinfection.

Dr. Sutton is in accord with Tait and Price on the question of pelvic abscess, and attacks all pus accumulations in the pelvis through the abdominal wall, unless pointing has occurred in the vagina. In a case recently done at his private hospital the abscess had been discharging per rectum. The operation was followed by a fæcal fistula which, however, entirely closed within the first few weeks.

Case XIV. Double salpingo-oöphorectomy. Diagnosis:—atrophy of right ovary; left ovary cystic and enlarged. Mrs. N., aged 22. History of sterility, menorrhagia, dysmenorrhœa and great pelvic pain.

Operation June 12, 1892. Dr. Joseph Taber Johnson, of Washington, being Dr. Sutton's guest was requested by the latter to operate. The invitation was accepted and the operation was performed in accordance with Dr. Johnson's well-known

skill. No sponging or flushing. Recovered. Discharged June 23, eleven days after operation.

Case XV. Single ovariotomy. Diagnosis:—dermoid cyst. Miss S., aged 32. History of great pelvic pain, dysmenorrhœa, etc.; examination revealed fluctuating tumor in right pelvis.

Operation June 16, 1892. Cyst of right ovary size of an orange, removed intact. Containing skin and hair in interior of second daughter cyst. No sponging or flushing. Time 11 minutes. Convalescence uninterrupted. Discharged July 1.

Case XVI. Double salpingo-oöphorectomy. Diagnosis: Double pyosalpinx. Mrs. S., aged 26. Sterile for six years. Attack of gonorrhœa from husband soon after marriage. Severe attack of peritonitis while at hospital, a short time previous to operation. Examination:—large masses on both sides of uterus, latter being firmly bound down.

Operation, June 18th, 1892. Universal dense adhesions. Operation very difficult. Pus in both tubes. Tubes and ovaries on both sides removed. Abdomen flushed and closed. Time, 30 minutes. Recovered; rather tardy convalescence.

Case XVII. Single ovariotomy. Diagnosis:—solid tumor of right ovary, probably a myoma. Miss S., aged 33. Tumor first noticed five years previous to admission.

Operation, July 19th, 1892. Solid tumor of right ovary of about six pounds weight. Adhesions to abdominal parieties, uterus, bladder and floor of pelvis. This operation was also quite difficult. Pedicle was tube which required ligation before the delivery of the tumor could be effected and great difficulty was experienced in accomplishing the latter. The operator succeeded in insinuating his hand between the tumor and its pelvic adhesions, and then forcibly wrenched it from its attachments. Abdomen flushed and closed. Time, 35 minutes. Recovered. Convalescence uneventful.

Case XVIII. Intraligamentous cyst. Miss T., aged 29. History: One child seven years prior to admission; had been an invalid since that time. Large mass on examination in right pelvis. Operation, June 27th, 1892. The presenting portion of the cyst was stitched to the abdominal wound, incised and about a quart of serum and pus evacuated. The cavity was then carefully cleansed, the sutures withdrawn and the cyst enucleated. The enucleation was attended with some hæmorrhage and was quite difficult in execution. The pedicle was finally ligated with tube and round ligament, at cornu of uterus. Left ovary was normal and therefore not disturbed. No flushing. Time, 30 minutes. Recovered. Convalescence uneventful.

Case XIX. Double salpingo-oöphorectomy and anterior fixation of uterus. Diagnosis:—procidentia uteri, both ovaries prolapsed and hypertrophied. Mrs. S., aged 42. History:—seven children, last, five years of age. Patient had been chronic invalid, bed-ridden much of the time since birth of last child. On examination both ovaries were prolapsed, hypertrophied and exquisitely tender and the uterus procidnous.

Operation, June 28th, 1892. Abdomen very fat and flabby. Both ovaries were large, cystic and hæmorrhagic; both removed and uterus stitched to lower angle of wound, with two buried silk-worm gut sutures. No flushing or sponging. Uneventful convalescence.

Case XX. Double salpingo-oöphorectomy. Diagnosis, prolapsed ovaries, chronic salpingitis. Miss C., aged 19. Bore one child at 17. Menorrhagia and chronic invalidism.

Operation June 29th, 1892. Both ovaries very large and cystic; chronic salpingitis. Tubes and ovaries on both sides removed. No flushing or sponging. Time, 15 minutes. Recovered; convalescence uneventful.

Case XXI. Supravaginal hysterectomy. Diagnosis:—fibroid uterus, chronic isalpingitis and ovaritis and pelvic pertonitis. Mrs. L., aged 46. Mother of seven children. Violent uterine hæmorrhages. Uterus on examination large and fixed.

Operation July 2nd, 1892. Right tube much enlarged and ovary composed of dense connective tissue and contained about four ounces peculiar looking fluid. The ovarian parenchyma was completely obliterated. Tube twisted once upon itself and with ovary firmly embedded in a mass of old dense adhesions and in similar condition, pathologically, as right side. Uterus bound firmly to promontory of sacrum and sigmoid flexure of colon. After separation of adhesions the uterus was drawn through the abdominal wound, bringing with it the sigmoid, still attached to the left horn. This was torn off and

returned to the cavity. The uterus was now discovered to be so injured that it was deemed wise to amputate it. An elastic ligature was consequently passed around the cervix. Attention was then turned toward the hæmorrhage, which had all along been very profuse. It was soon controlled after which two hysterectomy pins were passed above the ligature, the uterus amputated and the cervical canal seared with a Paquelin cautery. The operation then proceeded after the method of Hegar, e. g.:—The peritoneum was stitched with catgut continuously, below the ligature, and closed for the distance of about one inch above and below the stump, while the muscles and superficial tissue were allowed to remain open. The wound above and below was closed with deep sutures, in the ordinary manner. The tissues were then separated from the stump and the cavity firmly packed with iodoform gauze. The stump was next dusted with powdered subsulphate of iron and the whole closed in the usual manner.

Dressing changed on third, sixth and eleventh days; at latter dressing the stump was found to have separated and the ligature was consequently removed, leaving a cavity filled with healthy granulations. Not a particle of odor was noticeable at any time, the stump being completely mummified by the styptic. Patient made rapid recovery, sitting up in bed on sixteenth day.

Dr. Sutton is very favorably impressed with the elastic ligature. He states that his experience with it in the past two years was preceded by the loss of a case from secondary hæmorrhage, in which he used the *ecrasseur* of Koeberle. In this instance the neck of the uterus was soft and did not sufficiently resist the constricting wire, and the result as above followed, over a quart of blood escaping into the dressings before being discovered by the nurse. Since that event he has used the elastic ligature and has not lost a case.

The conclusion of this series of cases closes the reports until after Sept. 1st, 1892, when the gynæcological annex to the hospital will be re-opened. I shall then report the interesting cases as they present from time to time.

In summing up the work at this hospital since March 26, 1892, we find that there have been 21 abdominal sections, with 19 recoveries and two deaths.

THE EFFECT OF DISEASES OF THE EAR UPON THE GENERAL CONDITION.*

By WILLIAM CHEATHAM, M. D.,
PROFESSOR OF DISEASES OF THE EYE, EAR, THROAT AND NOSE, LOUISVILLE MEDICAL COLLEGE; EYE, EAR, THROAT AND NOSE PHYSICIAN, LOUISVILLE CITY HOSPITAL.

It shall be my endeavor in this short paper to cite some cases which have come under my observation in recent years, hoping they may be of profit not only to the general practitioner, but also to the aurist. The ear and its diseases appear to be less understood by the general practitioner than diseases of the eye, yet the former are of much more consequence than those of the latter, as more serious results are liable to follow their neglect.

The subject of this paper was brought to my mind on the day I received a note from our most worthy Secretary, asking me to prepare an article for this meeting of your Society. A prominent lawyer of our city had just made one of his monthly visits to my office to have his ear cleansed, saying his nausea had returned. On that day this gentleman said to me, "Doctor, you cured me three years ago of a cough that had troubled me much for several years, that had resisted all previous treatment." The cough has never returned. I remembered syringing from his ear a mass of inspissated wax and pus, and relieving him by treatment of quite an acute attack of inflammation of his external auditory canal. As I was wiping out his ear on the day of this conversation it made him cough, and recalled to him what relief I had given him by removing that mass three years before. Since then he has visited me frequently complaining of nausea; he has what we call necrosis of the attic of the middle ear, which has never healed, suppurating just the slightest all the time, and every four or six weeks pastes over the upper and outer parts of the external auditory canal with dried pus. When this accumulates to a certain extent he suffers a great deal from nausea and

*Read before the Mitchell District Medical Society at West Baden, Indiana, July 7, 1892.

comes in to have me remove it. This I do and relieve his nausea until there is another accumulation. His first reflex trouble was a cough; this has been replaced by nausea. The suppurating surface in this case has no connection with the middle ear cavity.

Reflex symptoms of this kind are not uncommon; in all cases of obscure cough which I am called upon to treat, it is part of my routine examination to look into the ears. Auditory canals of different indiduals differ very much in sensitiveness, as that of other parts of the body of the same individuals do. But that sneezing, cough, vomiting and even epilepsy may be the result of reflex irritation from the external auditory canal is beyond question. Fabucius, of Hilden, quoted by Roosa and other authorities on diseases of of the ear, reports a case of a girl ten years of age, who put a small glass ball in her ear, who was finally seized with hemicrania, anæsthesia of the left side of the body, alternating with severe pain, until at last epileptic attacks occurred, with other symptoms. Fabucius wrote his friend Bauhinus, that he had cured the child by removal of the foreign body. A Dr. Kupper, as quoted by Roosa, reported a case of epilepsy the result of a foreign body in the external auditory canal, and another of cerebral irritation the result of impacted wax; these cases can be easily multiplied. Some years ago I reported a case of a young lady from Central Kentucky, who had been treated for a persistent hacking cough; and had also been treated by a noted specialist of Chicago for some obscure nerve disease, whom I relieved entirely by removing from one ear a mass of impacted wax. Woakes not only admits that ear cough is common, but says by continued irritation of the auricular branch of the pneumogastric, derangement of the innervation of the laryngeal muscles may follow. Spasmodic croup he gives as one of the possibilities of this reflex action. Woakes traces the irritation (Roosa says, p. 206): *First*, from the vaso-motor fibres associated with the auricular branch of the pneumogastric. *Second*, to the secondary vaso-motor center the ganglion of the pneumogastric, whence he says it is deflected through sympathetic fasciculus, to the first crevical ganglion; *third*, thence by the nervi molles, to the vessels distributed to the mucous membrane of the larynx. He rejects the simple idea that the morbid impression is conducted along the sensitive fibres, from one region to another.

There yet remains in the minds of good men a doubt of the presence of a branch of the vagus in the external auditory canal. Quain and Fox says the branch of the pneumogastric supplies only the posterior part of the auricle, yet Fox has written one of the most extensive articles on ear cough ever printed. Clarke and Fox say ear cough has its origin "in the fibers of the fifth cerebral nerve distributed to the auditory canal." It remains a fact that ear cough is not uncommon, and that the weight of authority gives a branch of the pneumogastric nerve, distributed to the external auditory canal. Tissol reports a case of uncontrollable cough, the result of touching the external auditory canal. Teehlin reported with other cases, a case in the person of a military officer, who vomited considerably when ever his external auditory canal was touched. This sensitiveness may be in but one canal.

General Symptoms from Accumulations of Cerumen in the Auditory Canal: Aitken (*British Medical Journal*, No. 1630, p. 652) records three interesting observations in which general symptoms disappear after the removal of accumulations of cerumen in the auditory canal. In a little girl, eight years of age, with incessant cough, bad nights, frequent night-terrors, loss of appetite, and emaciation, without physical signs of pulmonary disease, one of the ears was found blocked with wax. In a man, eighty-one years of age, with restlessness, tremor, derangement of digestion, and deafness, the ears were found filled with large masses of hardened wax. A girl, eleven years of age, with a tuberculous family history, presented elevation of temperature, frequency and irregularity of pulse, but without other signs of organic disease. An accumulation of wax was found in the ear.

Not only wax and foreign bodies, but eczema, aspergillus, and furunculous inflammation of the external auditory canal may produce such symptoms as referred to.

Inflammations of the middle ear, and the danger therefrom I believe are beginning to be better understood than those of the external ear. Abscess of the brain, meningitis, pyæmia, phlebitis, mastoid

periostitis and necrosis, kidney complications from continued suppuration, are all well known results of suppuration of the middle ear. Abscesses of the brain (and middle ear suppuration produces a large majority of them) are getting rather common; many of them are now relieved by the trephine and incision or aspiration.

Cases of phlebitis as a result of middle ear suppuration are now relieved by tying the jugulars and curetting the brain sinuses. I have recently had a case of this latter trouble die before the mastoid could even be opened. I have recently seen a case of pyæmia in a stout healthy boy from Louisiana, the result of a subacute suppuration of the middle ear. Within the last week I have had two very bad cases of vertigo the result of acute suppuration of the middle ear. These cases are quite common. The last two cases mentioned were the result of pressure. Chronic catarrhal inflammations of the middle ear quite frequently cause vertigo. I have quite a number of such cases on hand, which have been treated by good men for cerebral and spinal trouble, as causing the vertigo. I have a lady under my charge now, who has frequent severe attacks of vertigo, which can be relieved only by the Eustachian bougie to dilate the tube, then inflation by the Eustachian catheter. Air cannot be gotten into the middle ear in this case except by use first of the bougie. I have one case of aural vertigo, in which the mouth of the Eustachian tube is dislocated, in which I had to pass the Eustachian catheter through the nose, and watch the instrument post-rhinoscopically and make a very long curious bend in the catheter before I could get air into the tube. Vertigo from disease of the internal ear is still better understood than that depending upon disease of either the external or middle ear. Meniere's disease has long been written of. The pathology of the disease has changed some in the last few years. These few notes I then hope will remind some of the gentlemen present, that in case of vertigo, cases of obscure cough and nausea, and other affections referred to, and some not mentioned, an examination of the ears should not be neglected. That suppuration of the middle ear is always dangerous; that the advice to let such cases alone, that they will outgrow it, is a thing of the past; that suppuration of the middle ear can cause pyæmia without involving the brain; such a case I forgot to mention, I saw with Drs. Bodine and Yandell, in which with other abscesses, there was one over the left scapula, which held about two pints of pus. Such cases cannot, of course, be relieved unless the cause is corrected. I could multiply instances enough of all the complications reported in this paper to fill many pages, but think enough has been said to show what diseases of the external, middle and internal ears can do, how they affect the general economy, and consequently how important it is to attend to them early and knowingly.

THE PREVENTION OF PURULENT OPHTHALMIA NEONATORUM AS A CAUSE OF BLINDNESS.

Frederick E. Cheney (*Boston Medical and Surgical Journal*, April 14, 1892.) prefers the title of Purulent Ophthalmia Neonatorum to that which is usually used to describe this condition, namely, Ophthalmia Neonatorum, for that affection which so often leads to blindness. The total per cent. of those blind being due to this cause is from 18.6 per cent. at the Perkins Institution for the Blind, to 26.02 per cent. in the asylums of Switzerland. Owing to the importance of this subject the New York Legislature has passed the following Act:

SECTION 1. Should any midwife or nurse having charge of an infant in this State notice that one or both eyes of such infants are reddened or inflamed at any time within two weeks after its birth, it shall be the duty of such mid-wife or nurse so having charge of such infant to report the fact in writing within six hours to the health officer, or some equally qualified practitioner of medicine of the city, town or district in which the parents of the child reside.

SEC. 2. Any failure to comply with the provisions of this Act shall be punishable by a fine not to exceed one hundred dollars, or imprisonment not to exceed six months, or both.

SEC. 3. This Act shall take effect on the first day of September, 1890.

Too little time has elapsed since the passage of the Act for statistics, but it is recommended that other states pass similar laws.

THE EFFECTS OF INTRA-NASAL OBSTRUCTION ON THE GENERAL HEALTH.*

By LEWIS C. CLINE, M. D.,
INDIANAPOLIS, INDIANA.

Nearly, if not every one can recall the time when they have experienced and felt the discomfort and depressing influence of an acute catarrhal inflammation of the mucous membranes of the nose, manifested by hyperæmia and hypersecretion, sneezing and obstruction, complete or partial, to the passage of air.

Only by a little careful thought on this subject do we realize the import of a clean, unobstructed breath-way through the natural channel. If stenosis from an acute cold of short duration is so potent in depressing one physically and mentally, what must be the effects, physically and mentally, of one who has permanent nasal obstruction?

Nasal obstruction in infancy is a matter of serious importance, as it may, in extreme cases, lead to paroxysms of dyspnœa and pulmonary engorgement, or may subject the child to starvation through inability to nurse. Every physician of experience can recall cases of fretful, ill-nourished babes from this cause. The moment the proper supply of air is diminished, the whole economy suffers for nutrition from deficient oxygenation of the blood. Typical examples of this are seen by every practitioner in children suffering from adenoid growths in the vault and enlarged tonsils, which give rise to the peculiar stupid facial expression. These children will all give histories of impaired appetites, restless nights with nightmare, directly in proportion to the obstruction, and no class of cases will respond more quickly to permanent improvement than they when the stenosis is relieved. Many of these cases can be traced directly to disturbed digestion and faulty nutrition, while the majority in children are due to traumatism, scarlet fever, diphtheria and measles. He, who gives the subject attention, cannot help being impressed with the intimate relation existing between naso-pharyngeal obstruction and the general health, as manifested by the stupid expression, muffled voice, faded complexion, flabby muscles, pinched features, spare forms, treacherous appetite, rebellious stomach, with strong tendencies to neuralgia, headache, worry, and loss of memory. In all cases of nasal stenosis, some or all of these symptoms are met with.

Those that are most liable to nasal obstruction from hypertrophy apart from the causes mentioned are not, as may be supposed, those that live out and are exposed to climatic changes, but on the contrary, they are those who live in-doors, such as work in dusty factories, stores, shops, and crowded cities where they do not have sufficient exercise in the open air and sunlight.

Thus we find that these cases come principally from three sources, viz:—1st. Traumatisms as falls or blows on the nose producing displacement of the septum, leading to hypertrophy and stenosis. 2nd. Scarlet fever, measles and diphtheria are a very common cause of stenosis in the young, leading to hypertrophy of the glandular and epithelial structures. 3d. From those who are most closely confined and suffer from the want of exercise and sunlight. These points should always be kept in mind, as they furnish the key to successful treatment.

It is my firm belief from observation and experience, in some cases, that many infants are treated with all sorts of drugs and soothing syrups for colic, when there is nothing the matter but ear-ache, caused by nasal stenosis, and all that is required to give relief is to clear the nose and inflate the ear. Many cases of asthma and sick head-aches can be traced to hypertrophy of the turbinates. Perhaps the following cases will best illustrate my text in adult cases:

Case I.—Mr. W., age 37, locomotive engineer, was referred to me for treatment April 11th, 1892, and gave the following history. For five years he had been a great sufferer from headaches. During the last two years, he had gradually grown worse, necessitating his laying off occasionally. Until three months ago when he had a great tendency to go asleep in spite of the effort to remain awake. On awaking from one of these naps he could not tell where he was or what station he had passed last, nor could he tell whether he had orders to run or not. His firemen had to tell him where he was and what

*Read before the Mitchell District Medical Society, at West Baden, July 7 and 8, 1892.

his orders were before he could realize the situation. This so frightened him that he took a leave of absence for two months. On examination I found his left nostril completely filled with a spur and deflected septum. The posterior ends of both inferior turbinates were hypertrophied, filling up the post-nasal space. The anterior tip of the middle turbinate on the right side was much enlarged, forming a hard tumor pressing against the septum. The pharynx was very dry and covered with a tough tenacious mucus. He could get but little air through the right side and his hearing was impaired. I began the treatment by removing the large nodule of hypertrophied tissue with the snare and the septal spur with the saw. As soon as the stenosis and pressure were relieved and breathing re-established, the headache was gone with all of the other symptoms complained of. He has now been running his engine for six weeks with but one slight attack of headache which followed getting wet and cold on a night run.

This patient says he has not felt as well in five years.

Case II.—Mr. R., pastor of one of our principal churches, and a great worker in charity organizations, consulted me on May 25th, 1892, on account of difficulty of breathing through the nose and the loss of power to concentrate his mind on his work or on any subject for any length of time. He was very forgetful, and was constantly annoyed by things that formerly did not concern him. He had become despondent, a thing foreign to his real self. In his own words, "To perform my work is like the task of climbing a marble monument with no foot-holds and nothing to grasp." Rhinoscopic examination revealed two large masses of hypertrophied tissue almost filling the post. nares, projecting well down over the soft palate. The anterior portion of the inferior turbinates was swollen and pressed against the septum. On removing the masses with a cold snare the patient experienced great relief, and as the treatment progresses the symptoms gradually subside. The case is still under treatment.

Case III.—On Feb. 8th, 1892, Mrs. O'B. was referred to me for examination. She had suffered repeated attacks of sick headache, more or less, for fifteen years, and had suffered no other sickness except that incident to child-birth. She stated that during the last three years her malady had gradually grown worse, so much so that during the last year she had developed a fear of becoming insane. She stated that during the last five years she thought she had spent as much as one day each week in bed from this cause. She also stated that at various times during all these years she had been treated for what her family physician called female trouble, to which he ascribed the headache, although he had never made an examination. Examination in this case revealed a hard tumor-like nodule, the size of a hazlenut, embracing the anterior end of the right turbinate body, pressing hard against the septum. There was some hypertrophy of both middle and inferior turbinates posteriorly, sufficient to cause stenosis when in the recumbent position. She, too, complained of lassitude, weariness and despondency. I removed the tumor with a snare and cauterized the hypertrophies, and to use her own language, "My happy girlhood disposition has returned." This case was under observation to May 15th, a period of over three months, up to which time there had been no recurrence of any of the old trouble.

I might extend these remarks to many like cases, but having already tired your patience, I will leave the subject with a plea for more rhinology and less stereotyped prescribing.

SALIPYRIN.

This body is a chemical compound of phenazone (antipyrin) and salicylic acid. In every one hundred parts there are 57.7 phenazone and 42.3 salicylic acid. It is prepared at the chemical works of Mr. J. D. Riedel, of Berlin, and has lately been introduced as a remedy which combines the physiological action of phenazone and that of salicylic-acid. There are some particulars in which salipyrin is said to differ advantageously from either of its constituents. It is stated that salipyrin is therapeutically effective without producing any functional disturbance. It occurs in the form of very small colorless crystals; the taste is not at all unpleasant, and may be described as slightly astringent and acid. It is very sparingly soluble in water, freely in alcohol. On account of its insolubility in water salipyrin is best administered in its compressed state or in cachets.

A FEW NOTABLE REMEDIES.*

By S. E. MUNFORD, M. D.,
PRINCETON, INDIANA.

Strychnia.—As this remedy is usually prescribed, I doubt if we are ever sure of benefit from it. It is believed to be a tonic in worn-out nervous conditions and to aid in the treatment of gastro-intestinal troubles. It is prescribed in doses from $\frac{1}{75}$ to $\frac{1}{15}$ of a grain, combined usually with iron and the bitter remedies. To learn to respect the drug we need to give it in a case of acute general chorea, according to the dosage instituted and practiced by Trousseau, or as near thereto as the courage of the practitioner will allow. He dissolved one grain of the sulphate in twenty teaspoonfuls of syrup (℥iiss), each teaspoonful containing therefore $\frac{1}{20}$ grain of the salt. With children, according to the age, he administered at the beginning from one to three teaspoonfuls per day. The doses to be given at equal intervals of time during the day, so the effect may be watched. If the dose of three teaspoonfuls each day is well borne it is continued for two days and increased by one teaspoonful. After another two days the dose is increased by another spoonful, and so on until six teaspoonfuls are taken in the course of the day, *always at equal intervals of time.* When this dose has been reached two teaspoonfuls are given three times a day and increased according to the rules of the first course. Then a teaspoonful ($\frac{1}{2}$ grain) may be given and pushed until three, four or even five of these doses are given per day. In the case of adults the dose from the beginning may be two teaspoonfuls and increased to two grains of the drug daily. The administration of the remedy attended by the closest surveillance should not be stopped short of the physiological effects. When the patient complains of some stiffness of the jaws, slight giddiness, or stiffness of muscles of neck and back, the ascending scale of dosage should be stopped, and if the choreic manifestations are disappearing the dose may be lessened. I have never had occasion to reach the outer limits of administration of the drug according to Trosseau's rule, for the reason that my cases have yielded before that limit was reached. The doses are heroic and the method has been denounced as dangerous. I am satisfied from my own observation that an individual with a violent attack of chorea is wonderfully tolerant of the drug. It is pretty safe to follow the master clinician.

Morphia.—I have only to remark with reference to this drug that it is given usually in larger doses than are needed to secure the desired effect. When we deal with spasmodic, hepatic, or renal colic a full dose is imperative. In a majority of the cases in which morphia is administered one twenty-fourth of a grain will be found to be sufficient. One-fortieth or even one-sixtieth of a grain will relieve moderate pain and quiet a bed-wearied patient. I spent last summer in bed and had some experience with this remedy. Two grains of the sulphate of morphia were sufficient for the pains and weariness of the entire attack. I use the hypodermic tablets for internal use, grain $\frac{1}{4}$, and divide into the dose I may want by teaspoonfuls of water.

Phosphate of Soda.—This drug is cholagogue in effect. If continued in sufficient doses it increases the biliary flow. It is helpful in all cases of gastro-intestinal catarrh. In the duodenal catarrh of children attended with mild fever and slight jaundice, ten to twenty grains of the phosphate in solution, repeated several times a day, give relief. I call up the remedy on this occasion to say that it is the one reliable agent in all the list of remedies for the prevention of the inspissation of bile and the crystallization of cholesterine, resulting in the formation of gall-stones. It will not relieve the pain occasioned by a calculus in its exodus from the gall-bladder. It will not dissolve concretions already formed; but given continuously in large doses—six to eight drachms daily—it will certainly stop the formation of bilary concretions and cure the patient. A few years since I saw a woman who had suffered for two years with frequent recurrences of hepatic colic. Gall-stones had been passed, leaving no doubt as to the diagnosis. The patient was reduced in flesh, bore food badly, and was thoroughly dyed with the bile stain. Several good practitioners had seen her as consultants at different times, and I said to the attending physician: "There is no opportunity for me. You have with the aid of these men doubtless compassed the whole field of

*Read before the Mitchell District Medical Society at West Baden, Indiana, July 7-8, 1892.

therapy." But when he told me of the remedies used phosphate of soda was not in the list, we gave this remedy and cured the patient.

To Roberts Bartholow we are indebted for having indicated to the profession a remedy well-nigh magical in preventing the formation of biliary concretions.

HYPNOTICS.

By E. P. EASLEY, M. D.,
NEW ALBANY, INDIANA.

I wish to disclaim at the outset the knowledge of anything new in hypnology. My experience with these agents has doubtless been quite similar to yours, but by giving you my views of them your own will be strengthened or confirmed, and in this way I trust my remark may be of benefit to you.

We are often confronted with cases where it is imperative to produce sleep, and the choice of a hypnotic then becomes a matter of great moment. The list of somniferous drugs is long and quite a number of them reliable, but no one of them is applicable to all cases or ages. So many things must be considered in making a selection that the question is indeed one of great perplexity. We desire to give an opiate for instance. Constipation may exist as a contra-indication, or the patient may be intolerant of opium in any of its forms. Again, a weak heart may contra-indicate the employment of chloral or sulfonal. Paraldehyde and somnal are so often repugnant to the taste as to be inadmissible, and so on by exclusion every hypnotic may be eliminated from the list. Here we can only make choice of the least evil, select the agent having certain merits and demerits, it is difficult to decide which is the most valuable, which one is acceptable in the greatest number of cases. Bromidia should have, perhaps, first place with sulfonal a close second. The former, containing cannabis indica, a heart tonic, can be pushed further than can chloral alone owing to its depressing powers.

Sulfonal in doses of 20 to 40 grains often acts magically. It frequently fails altogether however. It should be given in solutions, or it may pass entirely through the alimentary canal undissolved. This I have frequently observed. It should be administered four to six hours before bedtime as its action is slow. It has the disadvantage of being followed by stupor and muscular exhaustion continuing through the following day and besides is not altogether free from danger, great depression sometimes following its use. When sleeplessness is due to pain, then opium or some of its preparations is the remedy. Morphia given hypodermically is the best. Papine is a most excellent form of opium, being almost wholly free from the disagreeable features that attach to the other preparations of this drug, and is well tolerated by very young children. One drachm of it is equivalent to an eighth of a grain of morphine. It acts peculiarly well in the wakefulness of lying-in women.

The syrup of Dover's powder I have found to act well as a hypnotic in typhoid fever. Codeia is not reliable and makes the throat and tongue very dry with a disagreeable taste.

Antifebrin has some hypnotic properties, and by relieving pain invites sleep. The same is true of the other analgesics.

Paraldehyde is seen at its best in the wakefulness of delirium tremens. Its nasty taste is unbearable to any one in his senses. Chloralamid in 20 to 40 grain doses is a favorite with some, but I have never found it effective. Bromide of potash scarcely deserves the name of a hypnotic, though as a placebo it may be of some use.

We have no ideal hypnotic unless it be, according to the newspaper paragrapher, the modern sermon. If we believed him, that is almost sure to "weigh the eyelids down and steep the senses in forgetfulness," and is more potent than all the drowsy syrups in the world. Then there are no contra-indications to its use. It is applicable alike to young and old. It has no disagreeable after-effects. It begets no *habit*, is easy of administration, and is cheap enough, being had without money and without price.

We should always bear in mind that there are many auxiliaries we may employ to aid the action of hypnotics. The condition of the bed should be made comfortable, the light and temperature properly regulated, company excluded, and any noise prevented, and the patient advised that his medicine is given for the purpose of producing sleep.

*Read before the Mitchell District Medical Society July 7th, and 8th, 1892.

Society Reports.

MITCHELL DISTRICT MEDICAL SOCIETY.

Twenty-second Annual Meeting Held at West Baden, Indiana, July 7th and 8th, 1892.

FIRST DAY—AFTERNOON SESSION.

The Society convened in the hall of the West Baden Hotel, and was called to order at 2 P. M., by the President, Dr. E. S. Elder, of Indianapolis.

After the transaction of some miscellaneous business, the reading of papers was proceeded with. The first paper read was by Dr. C. W. Murphy, of Salem, Indiana, entitled

THE COAL TAR DERIVATIVES; THEIR USE AND ABUSE.

Antipyrin, acetanilid, antikamnia and phenacetine being the most frequently used and important of the newly discovered chemical agents, the speaker's remarks were confined principally to their consideration. Antifebrin and acetanilid are the same articles under different names. When the physician prescribes acetanilid he gives its pharmaceutical name; when he prescribes antifebrin he gives its proprietary name; the former is very cheap, the latter more expensive. Both are said to possess the same therapeutical effects, but a somewhat extended use of each one leads the author to believe that for uniform activity antifebrin is the more reliable. As there are no restrictions on the manufacture of acetanilid it is easy to understand how, as in the manufacture of other drugs, an impure article is sometimes placed upon the market.

All of these agents come under the head of anodynes or analgesics, possessing the property of lessening the sensibility of the nerve centers or their peripheral extremities, but in varying degrees. They are also antipyretic in action, and it should never be overlooked that their effect on the system when fever is present is much more powerful than when it is absent; that doses of considerable size can be given for the relief of pain with impunity in the absence of a rise of temperature, that would bring on a fatal collapse in high febrile conditions. While opium will always stand at the head of anodynes, its objectionable features of generally inducing constipation, cephalalgia, nausea and deranged digestion cause us to make use of the less harmful remedies for the relief of pain in a large class of ailments. As an anodyne, antipyrin he believes to be the most powerful of all the aromatic series. It is especially useful in rheumatism as a palliative in relieving pain, reducing the temperature and procuring sleep at night. In facial neuralgia, migraine, sciatica, pruritus and neuritis it is an excellent remedy for the relief of the pain. The dose should be ten or fifteen grains, and if the pain is not relieved in one or two hours, repeat the dose. Antikamnia, acetanilid and phenacetine are also useful in hemicrania; and all four can be depended upon for the certain relief of hyperæmic headaches. The speaker has many patients who prevent paroxysms of sick headache by one or two doses of antifebrin of six to eight grains each. Some get relief from antipyrin when antifebrin fails. He had used phenacetine in a number of cases of pertussis, and believes it serves a useful purpose in diminishing the severity and frequency of the paroxysms of coughing. For the relief of enteralgia, gastralgia, and other nervous affections of the bowels, dependence cannot be placed upon any of these; but antikamnia has given relief in a number of cases of the lighter forms of these affections. All of the series have a wide range of usefulness in the treatment of *la grippe* in relieving the severe muscular and neuralgic pains and in reducing the fever. He had cured in three days an eighteen year old girl affected with choreic movements of the left arm, neck and face of uncertain ætiology by giving ten grain doses of antipyrin three times a day. He had also used antifebrin and antipyrin successfully in ten to twelve grain doses in simple nervous insomnia.

The use of all antipyretic remedies must be persisted in until the desired end—the reduction of temperature,—is secured; but the peculiarities of each patient must be studied and these agents must be administered in a way to suit each individual case. A dose that would give the desired result at one period of a disease might prove insufficient or excessive at another period; and a dose that would lower a temperature to the required degree in one individual might require double that amount to get

the same result in another. Many authorities recommend giving five to ten grains regularly every three or four hours. This practice should be deprecated, for such a quantitity is likely to disintegrate large numbers of red corpuscles, cause blueness of the lips, cold extremities, excessive sweating, subnormal temperature and such untoward effects would more than counterbalance the good accomplished. It is well known that in nearly all fevers there is an evening exacerbation; usually the fever rapidly declines after midnight, and does not rise again until 10 or 11 a. m., and sometimes not until 2 or 3 in the afternoon. A powder of seven or ten grains in the morning when the temperature has risen to 103° will generally keep it down below the point until 7 or 8 p. m., and occasionally it is sufficient for the twenty-four hours; but if it comes up again any time in the afternoon or evening another dose is given. Should one dose fail to make an impression on the fever, which but seldom occurs, the author gives another dose at the expiration of two hours. In this manner, with from one to three doses the temperature in almost all fevers is easily maintained below 103°; and as already stated, it prevents undue tissue waste, lessens nervous irritability, promotes sleep, prevents delirium and complications, and therefore lessens the mortality.

The essayist in conclusion said that the opinion was entertained by many that the antipyretic form of medication does more harm than good; but he believes that such a conclusion is based upon improper dosage and too frequent administration.

Dr. William Bailey, of Louisville, has not prescribed antipyrin for years because of the disagreeable effects observed following its administration. He does not prescribe antikamnia because it is not strictly one of the coal tar derivatives, but a made up preparation, and ought not, in his opinion, be prescribed. He uses phenacetine more frequently than all of the others together for the reduction of temperature, and gives it without hesitation under all circumstances. His method in treatment of typhoid fever is to take care of the patients, feed them carefully, treat them with phenacetine and salol, and disinfect the alimentary canal by the nitrate of silver.

Dr. E. D. Laughlin, of Orleans, Indiana, thought the profession was down on antikamnia and it had a right to be; that its antipyretic properties are entirely owing to the amount of acetanilid that it contains, 75 per cent. of acetanilid, and 25 per cent. of bicarbonate of potash, the preparation being made by a firm in St. Louis. He found penacetine an excellent thing in pertussis and whooping cough when properly administered, three times a day. He had been able to control the paroxysms of cough with it. In typhoid fever he uses acetanilid in connection with other drugs. As an antipyretic he uses it almost exclusively. He has no disposition to change for the reason that it gave him satisfaction. He thought if bicarbonate of soda with acetanilid had been taken together in the case mentioned, the headache might have been relieved.

Dr. J. M. Mathews, of Louisville, could see no justifiable reason why antikamnia should be ruled out of the list of remedies mentioned, because it is a combination and put up by some house in St. Louis. The speaker said he had been a sufferer from periodical headaches all his lifetime; he had tried the coal tar derivatives, some of them acting fairly well, others doing him injury, but antikamnia in his own case had given entire satisfaction, so much so that when he has an attack he can stop it almost instantly with antikamnia in 15 or 20 grain doses.

Dr. James T. Ball, of Judson, Indiana, does not use the preparation of antikamnia as put up by the St. Louis firm, but makes a combination himself. It is cheaper, and he considers it the safest of all the preparations he has used. To four ounces of acetanilid, he adds one ounce each of bicarbonate of soda and salol, triturating thoroughly. This combination is identical both in appearance and effect with the preparation manufactured in St. Louis.

Dr. Dudley S. Reynolds, of Louisville, said the paper awakened in his mind a consideration of the whole subject of the treatment of the inflammatory, zymotic fevers, antipyresis, etc. In 1882 a discussion of Brand's method of treating typhoid fever was extensively indulged in by the French Society for the Advancement of Science. An eminent Frenchman had been making experiments with salicin, quinine, and some of the other alkaloids of the cinchona bark. All the great clini-

cians of France took part in the discussion. The impression was that high temperature means disintegration of tissue; it means the active processes of fermentation, carefully studied most all the remedial agents employed against these processes will convince one that they are in the nature of anti-ferments. In the chronic inflammations of the so-called rheumatic people, especially the chronic inflammations of the ciliary body of the iris, all the different kinds of medicine used in the treatment of high temperature had been tried—all the eliminating agents, all the depleting agents and mercurial drugs, which had so long been in high esteem by the profession had almost entirely passed out of use. We now find phenacetine, salol, salicylate of sodium, and more rarely pilocarpine bring about not only reduction of pain, discomfort, and of the general bodily temperature, which is always elevated in inflammations of the ciliary body, but actually dissipate the inflammatory process by opening up the lymph channels and tubes by destroying the ferment that occludes them, whether by dissolving some morbid effusion or by general diffusion it is difficult to say, yet the conviction in the minds of Frenchmen was that antipyretics are after all anti-zymotics, those agents which arrest fermentation.

Dr. E. S. Elder, of Indianapolis, expressed his appreciation of the paper, and was glad that the author had taken such a bold stand in favor of antipyretic medication, as he believed that an unfounded prejudice had been created against their use by certain members of the profession who claim that antipyretics assist in producing heart failure. He believed that the injury charged to antipyretic medication resulted from continued high temperature, which meant increased metabolism or a burning up of the tissues, which of itself was disintegrating, and weakening. Dr. Elder uses phenacetine largely in the place of antifebrin. Antipyrin he had not used for some time. He relies both upon acetanilid and phenacetine. He considers it good practice in the use of antipyretic remedies to combine with them some heart tonic, such as strychnia or digitalis.

Dr. C. W. Murphy, of Salem, said if there was depression of the heart he used a cardiac tonic, otherwise not. He sometimes uses digitalis and nux vomica in combination. The principal reason for th condemnation of antipyretic medication by certain members of the profession he thought was due to an improper administration of the remedies themselves; that they were given in too large and frequent doses.

Dr. S. H. Charlton, of Seymour, Indiana, asked Dr. Murphy in what doses would he consider it safe to use these remedies, and how often. His experience was in favor of giving them in small doses. Five grains of antifebrin were as many as he gives, repeated every three or four hours. He had treated cases in the country by sending these remedies in connection with other medicines without seeing the cases. He also desired to ask whether the essayist or any other gentleman had used antipyrin or any of the coal tar derivatives in the treatment of cerebro-spinal meningitis.

Dr. Murphy said he did not use phenactine in the treatment of any kind of fever, that it was dangerous on account of its depressing effect upon the heart. As stated in the paper, he uses antifebrin in reducing the fever. When the temperature reaches 103° he gives it in from seven to ten grain doses according to the physical condition of the patient. Five or seven grains he considers sufficient in ordinary cases to reduce temperature. If it does not reduce it in two hours, he would repeat the dose. He had had no experience with antipyretics in treatment of cerebro-spinal meningitis.

Dr. William Bailey, of Louisville, thought phenacetine the safest remedy to give so far as the heart is concerned; but if he apprehends heart failure, instead of giving strychnia, he gives caffein.

Dr. E. P. Easley, of New Albany, Indiana, was surprised to find that antikamnia had so many friends, as he thought it was a therapeutical outlaw. He reported the case of a young lady, 22 years of age, weight 165 pounds, in robust health, where, by mistake, 24 grains of antikamnia were given for an ordinary headache with fatal result. He was firmly convinced that all antipyretic remedies should be prescribed with great care.

Dr. Dudley S. Reynolds, of Louisville, remarked in regard to dosage, that in an acute attack of iritis or cyclitis in a patient able to go about, or who had no heart complication, one or two grains of phenacetine every hour would in about

twenty-four hours dissipate all manifestations of the inflammation in many instances. Of course, it was not always uniformly successful. He believes that small doses frequently administered will bring about the desired effect with more certainty and uniformity and with less danger to the heart.

Dr. William Cheatham, of Louisville, read a paper entitled

THE EFFECT OF DISEASES OF THE EAR UPON THE GENERAL CONDITION (see p. 256).

Dr. F. C. Heath, of Indianapolis, Indiana, read a paper entitled

PRACTICAL SUGGESTIONS TO THE GENERAL PRACTITIONER IN EAR TROUBLES.

The purpose of the paper was to give a few suggestions in the management of ear troubles necessarily treated by the general practitioner, such as foreign bodies in the ear, earaches and purulent discharges from the ear.

The foreign bodies most likely to be found in the ear are, in adults, forgotten masses of cotton and various insects; in children, pebbles, beads; corn, beans, and other articles put in the ear by the little patients themselves or their companions. Such cases are very likely to fall into the hands of the family physician. What is he to do with them? The most useful and effective instruments for the removal of these bodies is the syringe. Warm water should be used, and it should be gently injected. By this simple means the majority of foreign bodies may be quickly and safely removed from the external auditory canal. An effort should be made to direct the water to one side of the object that we may get on its return a *vis a tergo*. Otherwise the force of the water may carry the body farther into the canal. This danger is still greater in case of objects so large as to fill the lumen of the meatus. Straightening the canal by pulling the auricle a little upward, outward and backward will facilitate matters. Beans, corn and other articles likely to swell from contact with water should either be removed altogether with instruments (hooks, scoops, and forceps), or, if the syringe is used without success, there should be no delay in resorting to instruments. Insects may often be killed by solutions of chlorinated soda or choloform previous to removal with syringe, if the hook-like appendages of larvæ becomes so attached to the tissues that syringing fails they may be picked out with forceps. While foreign bodies may cause trouble by exciting pain or inflammation, this is far less common and less serious than that produced by injudicious and unsuccessful efforts at removal. Destruction of the drum-membrane, injury to the ossicles, loss of hearing, facial paralysis, and even death resulted in these cases. It behooves the surgeon, therefore, to see what he is doing and proceed with care. The canal must be well illuminated and instruments manipulated in such a way that objects may not be pushed, or allowed to slip further in. If unable to come up to these requirements and where the syringe fails, the good of the patient as well as the reputation of the physician and of the general profession require the transfer of the case to more competent hands.

Accumulations of hardened wax may be removed usually according to the rules already laid down, but some cases will require the previous use of an alkaline solution or other means for softening the mass.

A more frequent trouble in the practice of the family doctor is earache, often very severe. This may be neuralgia from the teeth or other causes, in which case removal of the cause and anti-neuralgic treatment are indicated. But far more commonly it is due either to acute inflammation of the middle ear or furuncle of the external auditory canal. The greater pain, tinnitus, and impairment of the hearing in the former affection will aid in differentiating—also inspection of the canal and drum head. It a fatal mistake to regard the earaches of children as trifling—so many of them are attacks of acute inflammation of the middle ear, resulting in more or less impairment of hearing, and in some cases, of course, still more serious affections follow both in children and adults. The remedies used for these troubles are numerous and various. Some of the most disgusting are skunk oil and human urine. The means most effective both in furuncle and otitis media are heat and blood-letting. Heat may be applied in various ways—blowing in the warm breath, or dropping in hot water with a medicine dropper, answer well in many cases. A hot water bag placed against the auricle is very efficient; a simple substitute is a hot water bottle wrapped in a towel or napkin against which the ear may

be laid. But perhaps the best method in middle ear inflammation is douching the ear with hot water from a fountain syringe for ten or fifteen minutes at a time as required for the relief of pain. This should not be overdone on account of the macerating tendency on the drum-membrane, and the liability in furuncle to produce diffuse inflammation.

When hot applications fail, blood-letting should be resorted to. One or more leeches should be applied to the tragus (in front of the ear,) not to the mastoid unless that is diseased. They give great relief in middle ear troubles, but often fail in furuncle. The latter trouble may be relieved by painting with tincture of iodine or a 20 per cent. solution of menthol in benzoinol. We may incise, or preferably puncture, early in the case, with less pain to patient after the formation of pus. In either affection morphia and atropia solutions may be used, although not very reliable as a rule, nor so effective as the measures already suggested.

Purulent discharges from the ear trouble the general practitioner as well as the specialist. The origin of this discharge is sometimes in the external canal, but far more often in the middle ear. The doctrine that we should not meddle with the ear, that the discharge is salutary and not to be checked, is a pernicious one held not only by the laity, but also by some of the profession. The fact is these discharges are often serious—caries of bone, meningitis, cerebral abscess, pyæmia and death are among the possible sequelæ. Pyoktanin is said to be effective in this affection. In using this, as well as silver solutions, care is necessary to avoid staining the clothes or person of the patient. Peroxide of hydrogen is contra-indicated in acute troubles of the ear, but very successful in chronic discharges. Although it is often used in full strength, the essayist prefers to dilute it, having seen it on one occasion produce severe inflammation.

But the question may occur to some practitioner, "shall I use the Politzer air-bag or other means of inflating the middle ear in these cases of earache and purulent discharges?" Many a routinist thinks of this as a remedy for all ear troubles just as he does of digitalis for the heart and atropia for the eye. Inflation is indeed valuable in many of these cases, but it should be used with care and moderation. In purulent affections it is an aid in cleaning out the ear and in earaches from acute (or subacute) otitis media it may be found of service. Inflation should be made gently and tentatively at first (if at all) in the acute stages of these troubles lest they be rendered worse instead of better. But often by opening up the eustachian tube, dislodging pus, mucus or serum, restoring the memorana tympani to its normal position and equalizing the air pressure on both sides of the membrane, pain is relieved and inflammatory products are absorbed. This may be accomplished either by the Politzer or the Valsalva method, the latter consisting in puffing out the cheeks forcibly with nostrils and mouth closed. Sometimes the reverse is of benefit, swallowing with mouth and nostrils closed, thus causing a partial evacuation of the contents of the middle ear, air, serum, mucus or pus.

These suggestions are offered not as an exhaustive or technical discussion of the subject, but in the hope that they may not be entirely without practical value to the general practitioner in treating the common forms of ear troubles coming under his charge.

Dr. L. C. Cline said that ear cough, referred to by the essayist (Dr. Cheatham), was frequently overlooked by the general practitioner, who treated cases for months without benefit, thinking the trouble was in the throat or bronchial tubes. He reported the case of a school teacher, who had been treated for nine weeks without benefit. Her cough was so bad that she could not sleep until after 12 P. M., without some anodyne to relieve it. Examining the ear he found it impacted with wax and suppurating. He touched the ball of wax with his probe and the patient screamed. The cough he thought was due to the wax in the ear as its removal was followed by relief of all the symptoms. He had seen other cases.

Dr. S. E. Munford, of Princeton, Indiana, mentioned a case of chronic suppuration of the ear in which he cleansed the ear with peroxide of hydrogen. About a week thereafter he had to chisel open the mastoid cells. He believed that the peroxide forced purulent matter into tne mastoid cells.

Dr. Dudley S. Reynolds said, that while the syringe was useful in removing foreign bodies and accumulations of pus

from the ear, it was, at the same time, attended with danger, and corresponding importance should be attached to subsequent inflation by the Valsalva or some other method.

DR. S. H. CHARLETON said, in the few cases of suppuration of the middle ear that had come under his observation, he had perforated the drum and evacuated the pus early, the patients doing well. He had seen bad effects in some cases from negligence, but never saw a person die from suppuration of the mastoid.

DR. C. W. MURPHY asked Dr. Heath in what form he used boric acid, whether in powder form or solution.

Dr. Heath replied that he used it in powder form in the chronic cases. In the acute cases, if the suppuration did not yield quickly to cleansing measures, he would resort to it as in the chronic form.

The papers were further discussed by Drs. Yost, Cheatham, Reynolds, Cline, Ball, and Bailey.

Dr. L. C. Cline, of Indianapolis, then read a paper entitled: THE EFFECTS OF INTRA-NASAL OBSTRUCTIONS ON THE GENERAL HEALTH. (see p. 259.)

Discussed by Drs. Cheatham, Charleton, and Cline.

DR. E. P. EASLEY, of New Albany, Indiana, followed with a paper entitled HYPNOTICS. (see p. 262.)

EVENING SESSION.

The Society was called to order by President Elder at 8 P. M. Dr. Dudley S. Reynolds, of Louisville, took the chair and Dr. Elder delivered the President's Address.

He said that one of the most important considerations in connection with the meetings of the Society was to make them practical. The prime object should be to give the greatest amount of practical information, so that every member will learn something that he can at once utilize in his every-day work. Dr. Elder then presented some thoughts relative to recent studies and teachings in medical science during the last year.

The past year has witnessed marked growth in many departments and a definite solution of many problematical questions.

One year ago he presented to the Society a paper defining recent views regarding pyrexia, hyperpyrexia and fever; that while animal heat was considered to be the result of metabolisms, yet it was directly influenced and controlled by the nervous system, and that the thermogenic function of the nervous system was one of its most important. This thermogenic function consists of three factors, viz., heat production (thermogenesis), heat radiation and loss (thermolysis), and heat regulation or thermotaxis; that a disturbance of either of those functions produced pyrexia or hyperpyrexia. And further that these thermic disturbances alone were not fever, but that fever came on in connection with pathological conditions other than these variations of temperature. Those views have passed into the domain of accepted verities. We know that the mere presence of abnormal heat is not the measure of the pathological process. We may have an exceedingly high temperature from retarded thermolysis, heat production being small but its escape retarded and a high temperature results. On the other hand, heat production may be enormous and its radiation equally rapid, consequently a high temperature does not ensue, yet our patient is most dangerously sick.

The most important advance in medicine during the last twelve months has been in the department of bacteriology. This vast field now yields fruits which are rapidly controverting old opinions and establishing on logical and firm foundations a new ætiology, pathology and therapeutics.

Dr. Elder then laid before the Society the very latest precise knowledge on the subject of bacteriology, as set forth only a short time since by Dr. Geo. M. Sternberg, of Washington, after which he passed to the examination of a few more pathological conditions in the most advanced light of modern research. He called particular attention to erysipelas and diphtheria. Erysipelas has always been the source of controversy, its ætiology and therapeutics were unsettled and unsatisfactory. Recent pathologists place it among the contagious, infective, specific diseases. That it is a disease of microbic origin seems incontestable. The contagiousness of erysipelas has been recognized for centuries, and on this account early attempts were made to include it among microbic diseases. The speaker touched upon the discovery of the streptococcus of erysipelas by Fehleisen in 1883, gave a description

of it, and then dwelt at length upon inoculation experiments, the manner of infection, and the relation of erysipelas to phlegemonous inflammation and suppuration.

Viewing erysipelas as a microbic disease the treatment resolves itself into two prominent indications: (1) The destruction of the specific micro-organisms and prevention of its extension; and (2) the protection of the patient from ptomainic infection and from the invasion of putrefactive bacteria, and the general treatment to relieve the ordinary phenomena of inflammatory diseases, pain, fever and functional disturbances of the various organs. As remedies to destroy the specific microbe and to protect against the invasion of putrefactive bacteria, the remedy *par excellence* is bichloride of mercury. Layers of cotton wool saturated with a warm solution of bicloride of mercury 1-3000 to 1-5000, applied over the inflamed surface and covered with oil silk is the ideal local remedy. The speaker urged this treatment in lieu of all the various poultices, washes, paintings, coverings or other applications so freely and indiscriminately recommended without any definite conception of their utility.

To fulfill the second class of indications, viz., to protect against ptomainic infection either from the specific germ, or that of putrefaction, and from the effects of functional disturbance of the various organs, there is nothing better than these remedies which experience has so positively proven beneficial, viz., iron, quinine, and supporting measures. These should be given freely and constantly. Opium to relieve pain, antipyretics to control fever, digitalis and strychnia to sustain the heart, cholagogue cathartics to secure excrementitial hepatic function, diuretics if needed to assist the kidneys in eliminating effete matter, stimulants and supporting measures, are all indicated, as a matter of course, in this as in all maladies of a febrile nature. His plea is especially for the antiseptic local treatment, earnestly and intelligently applied, thereby saving much constitutional disturbance, thus avoiding the necessity of much systemic medication.

Passing to diphtheria we enter a most interesting field. Its history dates back to the times of antiquity. Nothing in the history of medicine has more clearly shown the progress towards an exact science than the study of this subject. There can no longer be any differences as to the disease being primarily a local or a constitutional one. It has been clearly proven beyond a question that a rod-shaped bacillus, first discovered by Klebs, alighting upon a susceptible mucous membrane, produces the characteristic local lesions. It has also been proven with equal certainty that the bacilli found in the diphtheritic exudate produce a chemical poision, and it is this that induces the constitutional symptoms.

Histological changes. We owe largely to the labors of Wagner, Weigert, and more particularly to the splendid work of Œrtel, our knowledge of the minute changes which take place in diphtheria. According to Œertel "The diphtheria poison induces first a necrosis or death of cells with which it comes in contact, particularly the superficial epithelium and the leucocytes. The deeper cells of the mucosa and of the other parts reached by the poison may be affected. The second change is a hyaline transformation of the dead cells, or as Weigert terms it, the production of coagulation necrosis. The bacilli excite inflammation with the migration of the leucocytes, which are destroyed by the poison and undergo the hyaline change. The superficial epithelial layers undergo a similar alteration, and when we know as the *false membrane*, represents an aggregation of dead cells, most of which have undergone the transformation into hyaline material. This is in all probability a conservative process, by which, in a measure, the poison is localized and prevented from reaching the deeper structures. The laminated condition of the exudate is probably produced by the inflammation of different layers. The formation of these foci of necrobiosis, starting from the epithelium and proceeding inward, is, according to Œrtel. the distinguishing characteristic of diphtheria. The action of the poison is by no means confined to the superficial mucosa on which the bacilli grow. Although they do not themselves penetrate deeply the contiguous bronchial glands show extensive foci of necrosis. In severe cases these necrotic areas are found in the internal organs, in the solitary glands of the intestines, and in the mesenteric glands."

The treatment of diphtheria consists of

three factors: 1, prophylaxis; 2, general treatment, and 3, local treatment. Cases of diphtheria should always be isolated. Clothing, utensils, play things, books, and other articles having been in contact with them should be carefully disinfected. Boiling, fumigation with sulphur, soaking and washing in the bichloride solution are the measures to be depended on as prophylactic agents. Persons liable to exposure should use antiseptic mouth washes, etc. The two prime indications in the general treatment of diphtheria are first to prevent or limit the local develment of the specific bacilli, and second to combat the effects ef the toxic materials which they produce. The most important factor in controlling the disease is the local treatment. Antiseptic washes, douches, sprays, and gargles are invaluable. Bichloride of mercury is the remedy *par excellence*, one to three or five thousand, used freely, often and assiduously offers us the most hope. Have patients to gargle every half hour bringing the fluid in contact with all the inflamed area and pseudo-membrane. A most important part of the treatment is to bring the medicine in contact with the specific bacilli. Frequently this can only be done by dissolving the false membrane. For that purpose, applications of lactic acid and lime water, vegetable pepsin (paypayotin) and trypsin. Lactic acid and lime water, two drachms to 6 ounces, and trypsin and water, 30 grains to one ounce. These are the speaker's favorites.

Dr. U. H. Hon, of Bloomington, Indiana, followed with an address entitled "The Outlook of Life To-Day." It was instructive and interesting.

SECOND DAY—MORNING SESSION.

The Society was called to order at 10 A. M. by the President.

Dr. Joseph M. Mathews, of Louisville, read a paper on

"HOW TO DEAL WITH FISTULA IN ANO."

He had once heard the elder Allingham remark that in his opinion "it required more surgical knowledge and dexterity to operate on and cure a complicated case of fistula in ano than any other surgical affection." The more Dr. Mathews met with this very troublesome disease the more he was persuaded of the truth of Allingham's assertion. Too little attention was given by authors of books to the details of the operation. He knew that the elastic ligature had strong advocates in Dittell, Allingham, and others, but the procedure seemed so unsurgical and withal so unsatisfactory, that but few surgeons had given the plan much endorsement. The more he used the elastic ligature in the treatment of fistula in ano, the less he liked it. When compared with the knife in operating for fistula, all other methods must suffer by the contrast. What can be accomplished by the knife in a few minutes, it took days or weeks for the other plans of treatment to do. Edges of wounds can be trimmed, additional sinuses sought for and divided, the bottom of all cut through, antiseptic surgery practiced, and a perfect cure effected, when the knife is used.

DR. DUDLEY S. REYNOLDS, of Louisville, followed with some remarks on "Abscess in the Attic of the Ear."

DR. S. E. MUNFORD, of Princeton, Indiana, read a paper entitled "A FEW NOTABLE REMEDIES." (See p. 261.)

DR. ALLEN PIERSON, of Spencer, Indiana, read a paper on the TREATMENT OF VARICOCELE. He referred to the recent monograph of Dr. G. Frank Lydston, of Chicago, in which some thirty or more operations were mentioned for the radical treatment of varicocele, nearly all of which were named after the operator who had been the chief promulgator of some particular phase of the operation. Nearly all of these methods seek to obliterate the diseased veins. The object of some was to make a suspender of the scrotal tissues and by relieving the tension of the dilated veins give them the opportunity to recover their normal tone. These might be properly classed among the palliative methods.

Leaving out of consideration those methods in which caustics, remedies to coagulate the blood in the veins and electrolysis are the agents employed to secure obliteration, the other purely radical methods seek to obliterate the veins (1) by subcutaneous deligation, (2) by open deligation, and (3) by open deligation with excision of a portion of the diseased veins. A clear understanding of what is to be done and the simplest and safest manner of doing it were necessities, especially to one whose practice was private,—away from the hospitals or public institutions of any kind,—in the homes of the people. The dread of operations on varices no

doubt arose, in part, from the results in such methods as Vidal's or Ricord's

With simplicity and safety in view we avoid making extensive incisions in a location where they become peculiarly a source of danger unless there existed some abnormality. In the normal arrangement of the veins and in subjects where there are no calcareous deposits in this location there ought to be no difficulty in isolating the veins from the vas deferens with its attending artery; this being done subcutaneous deligation ought to be as easily accomplished as ligation in the open method. The speaker then went over the steps necessary in subcutaneous deligation, and closed by saying that the comfort of the patient, the freedom from complication, and the success of the operation depended upon cleanliness in a great measure; that in a few cases that had fallen to his lot to treat in this manner the secondary operation had been needed in none, and the operation had been ideal to all, and it was only because the tendency of the practice in these cases seemed to be in the direction of the open methods that this method was thus spoken of that it might, in some measure, be a defense for its use.

Dr. G. Frank Lydston, of Chicago, read a paper entitled "Irrigation of the Deep Urethra and Bladder Without Catheter or Tube."

From personal observation he had been led to believe that there was the greatest possible variation in resisting power of the deep urethral muscles and vesical sphincter. He had noticed that in some patients it was quite easy to force fluids into the deep urethra and bladder, while in others as much force as was compatible with the integrity of the urethral walls might be employed without forcing injected fluids into these parts. Patients had themselves informed him that it was only with great care that they were able to inject the the urethra without forcing the medicament into the bladder, while others never made such complaint. He was at first inclined to attribute this difference to roughness of manipulation, but experiments had since proven to his satisfaction, that experience of these patients involved a point of great practical interest and importance. He had for many months been using irrigation with a short urethra nozel in the treatment of urethritis, and had therefore been able to gain some valuable experience in this direction. He found that in many patients there was little difficulty, the irrigator being about the level of the patient's head, on an average, in irrigating the prostatic urethra and bladder without either tube or catheter. This is accomplished with no discomfort to the patient as a rule. He had utilized this practical point in the treatment of posterior urethritis to great advantage. One of the advantages of this method of irrigation in prostatic troubles was the facility with which hot water might be applied directly to the prostatic sinus. By carefully adjusting pressure by means of the fingers, about the nozzel while the latter is *in situ* at the meatus, the entire urethra may be kept fully distended by the solution, while the excess of water is allowed to escape around the nozzel. In the treatment of urethritis this method of irrigation was far superior to that usually adopted. A very promising feature of the method, was the fact that the patient could easily irrigate his own bladder in quite a proportion of cases, something that he could not readily do *via* the catheter. The method is designed to meet the indications existing in a large class of cases in which irrigation of the bladder and prostatic sinus is demanded, yet catheterism was to be avoided if possible. Whenever we could accomplish the purpose of vesical or urethral irrigation without instrumentation, it was our duty to do so.

The following officers were elected:

President.—Dr. Dudley S. Reynolds, Louisville, Ky.

Vice-President.—Dr. C. W. Murphy, Salem, Ind.

Secretary and Treasurer.—Dr. Geo. W. Burton, Mitchell, Ind.

Place of next meeting,—Spencer, Ind. Time, December 29, 30, and 31, 1892.

The Society, after tendering its thanks to the management of the West Baden Springs Hotel, on motion, adjourned.

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Piper. nigr. in pulv.	cgms. 30.
Extr. gentianæ	gms. 1.5.
Essent. pervincæ	gtt. 1.

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Leading Articles.

VAGINAL EXTIRPATION OF THE UTERUS.

Free discussion and the publication of all results, whether good or bad, are the only means by which the profession can assure itself of the utility of any surgical or therapeutic procedure. The opinions entertained regarding the value of the operation of vaginal extirpation of the uterus and adnexa, by gynæcologists in this country, are well known to the majority of our readers. Recently, however, the subject has been actively discussed abroad, cases cited, and theories advanced. The results of these are interesting, embodying as they do opinions based upon the experience of some of the most eminent gynæcologists in Europe.

Segond, who was originally the most vehement opponent of Péan's suggested "uterine castration," but who was converted to the operation by a case of his own successfully operated upon by Péan, not long since reported to the Surgical Society of Paris the results of 23 operations performed by himself. The operation was always made in cases of suppurative processes of the tubes and ovaries.

There were four deaths—all resulting directly from the operation. Péan on the other hand, has reported 66 cases without a single death. The remaining 19 cases of Segond's completely recovered. Segond regards any disease of the tubes and ovaries which would require laparotomy as an indication for the vaginal extirpation of these parts. The chief advantages claimed by the upholders of the operation are, the absence of an abdominal scar and the impossibility of an abdominal hernia as a result of the operation.

Bouilly, another French writer, while never having performed Péan's operation, nevertheless expresses himself as being strongly opposed to it except in such cases where firm adhesions to the neighboring

parts and the presence of old fistulæ render the result of a laparotomy doubtful. He claims that in the vast majority of cases of disease of the ovaries and tubes laparotomy and not Péan's operation is indicated. Bouilly considers Segond's claims for the merits of the operation unfounded; that the number of cases as yet reported is not large enough to permit of any definite conclusion being reached; and that Segond's rate of mortality is certainly against rather than for the procedure.

Richelot also suggests that Segond's enthusiasm has carried him too far. While Richelot does not deny the superiority of Péan's operation in certain peculiarly adapted cases, yet he believes that the operation should never be attempted as a substitute for laparotomy unless specially indicated.

Bazy recognizes only two indications for the operation: First, a suppurative condition of both adnexa coupled with a poor general condition of the subject; Second, old lesions of the adnexa which deprive the latter of their functions. Even the last indication is, according to Bazy, open to objection, since the possibility of a restoration of the normal functions of the ovaries and tubes can only be determined by a laparotomy.

Terrillon, whose numerous writings on gynæcological subjects are well known to our readers, states that in his opinion Péan's operation has decided advantages over laparotomy in cases of suppuration of the ovaries and tubes complicated with intestinal adhesions. He has performed four such operations, all of which resulted favorably; in conclusion, he states that the operation is, however, rarely indicated, and should not be undertaken in the general run of cases as a substitute for laparotomy.

Pozzi, the Italian gynæcologist whose experience with laparotomy has been so extensive, is decidedly against the operation. He bases the reasons for this opposition on the following grounds: First, because the operation does not give better results than laparotomy, and because in laparotomy the diseased organ can be directly removed, while in Péan's operation it must frequently be left behind. Second, because the latter is equally severe an operation as laparotomy, and while in the former a possible mistake in the diagnosis cannot be controlled, it can be in laparotomy. Third, because the cosmetic advantages should not be taken into consideration at all.

Routier, in an article on the subject, while not speaking from personal experience, states that the good results he has had from laparotomies do not permit him to abandon it for any other method as yet offered.

Lucas Championiere, on the contrary, is convinced that in all cases where the suppuration if not confined to the ovaries and tubes, but has invaded the neighboring tissues, Péan's operation is undoubtedly indicated, and promises the best results. This opinion is, however, based upon theory only, since he has not met with a case in which he could apply the operation, and he acknowledges that the excellent results obtained by laparotomy would not justify its abandonment. He also calls attention to the difficulty experienced in diagnosing suitable cases.

Terrier claims that the operation should only be attempted when the case is one of pyosalpinx complicated with suppuration of the pelvis, and Reynier confirms this opinion.

We may also quote the results obtained by Segond in operations of total hysterectomy for cancer of the uterus, which he has recently published in the *Semaine Médicale*. In all he has operated upon thirty-three cases, twenty-five consisting of cancer of the cervix and eight of cancer of the body of the womb. His results were twenty-six recoveries and seven deaths. The causes of death were septicæmia, peritonitis, strangulation of the intestine,

hæmorrhage, and shock each one case; and two cases from subsequent peritonitis. Of those which recovered from the operation three had a return of the disease in three months; eight are alive but have not been examined; three seem completely cured, the operation having been performed in 1888 and there having been no sign of a return of the disease. The others have been lost sight of.

In conclusion, it may be justly claimed in view of the opinions of those foremost among European gynæcologists that in Péan's operation of vaginal extirpation of the uterus, ovaries and tubes, we have a surgical procedure which should only be undertaken under certain specified and rare circumstances, and that the asserted superiority Péan's operation over laparotomy cannot be supported by the meagre experience yet obtained.

THE OPERATIVE TREATMENT OF RETRO-DISPLACEMENT OF THE UTERUS.

Chaput (*Semaine Médicale*, 1892, No. 17), at the conclusion of a paper on this subject, summarizes as follows: 1. Simple retroflexion requires no treatment. 2. Retroflexion complicated with metritis and prolapsus is best treated by curetting and repair of the pelvic floor. 3. Alexander's operation is often difficult, and sometimes fails to keep the uterus in its normal position, or if the organ is anteverted the symptoms are not relieved. 4. Ventrofixation is preferable to the latter operation, since the surgeon is not only sure that he has replaced the uterus, but he not able to remove the adnexa, which are so frequently diseased.

Saenger (*Centralblatt für Gynäkologie*, 1892, No. 1) continues his controversy with Schücking relative to the operation devised by the latter, which he opposes on the ground that fixation of the anteflexed uterus is not the result to be aimed at in ventro-fixation, but rather shortening of the sacro-uterine ligaments with free mobility of the organ, as when it is supported by a pessary.—*Amer. Jour. Med. Sci.*

Book Reviews.

THE DIAGNOSIS OF DISEASES OF THE NERVOUS SYSTEM. A Manual for Students and Practitioners. By Christian Herter, M. D. Physician to the Class of Nervous Diseases, Presbyterian Hospital Dispensary, New York. New York and London: G. P. Putnam's Sons, 1892.

This book possesses originality in its arrangement which commends it, and the facts concerned in the diagnosis of nervous diseases are related in a fresh manner. It is given to the profession with the understanding that it is an elementary treatise, yet the text is full enough to make it serviceable to all physicians. The chief good points about the work are its system and practical bearings. Instead of a complete elucidation of the anatomy and physiology of the nervous system, only the important facts concerned in a thorough understanding of the sensory and motor pathways have been detailed, and credit must be accorded the author for the excellent way in which this has been done, and for the very comprehensive diagrams with which the text is interspersed in this portion of the book.

The second chapter, upon the symptomatology of nervous diseases, gives a description of symptoms with reference to their diagnostic and pathological significance. In this way the student learns the true value of symptoms, and this is more by their association in groups than by their individual worth.

In the third chapter, which is upon the localization of lesions, the author has given the important symptom-groups in connection with each lesion. Thus it will readily be seen that symptomatology has received special attention, being discussed from the standpoints of general symptomatology and in a special way as related to the pathology of nervous affections.

The fourth chapter is devoted to the nature of the lesion, and all the ætiological, symptomalogical and pathological facts have been gathered together in order to throw as much light as our present knowledge of the subject will permit. The facts which are learned from the diagnosis of the position of the lesion are also brought together, and play by no means an unimportant part in certain diagnoses.

Following this is a chapter upon clinical types of nervous diseases. The types are

clearly represented, and the claim of the author that "variations in type" and "transitional forms" have been duly recognized, must be allowed.

The next chapter is probably the most interesting of the book, and deals with the diagnosis between organic and functional disease. The book ends with a short chapter upon the examination of patients.

Taken as a whole, we think that the book will be chiefly of interest to those who desire to be specially familiar with nervous affections. It is a good student's book, and will be found very useful to the general practitioner.

VARICOCELE AND ITS TREATMENT. By G. Frank Lydston, M. D. Chicago: W. T. Keener, 1892.

In this monograph the author has given us a review of the subject of varicocele and its treatment in a concise yet comprehensive manner. The contents comprise eight chapters and eighteen illustrations. The text is written in a most agreeable style, which characterizes the author's articles.

The treatment of the milder forms of varicocele is, according to Dr. Lydston, altogether palliative. He states that in a large proportion of cases all that is necessary to do is to allay the patient's mental annoyance by a little sound physiological advice. Instruction in sound physiology and hygiene is necessary in all cases in order to keep the patient out of the hands of the quack on the one side and to assist in a cure on the other. Marriage is recommended as the best remedy in cases which the author terms "spermatic congestion." Regulation of the diet and active exercise is strongly recommended, as are cold flagellations and the use of a suspensory bandage as adjuncts to palliative treatment. The cure of this condition by coagulative electrolysis and caustics also receives thorough attention. Finally, the various operations which have been devised of late years are fully detailed. The book is a valuable addition to genito-urinary surgery.

DEBILITY FROM LA GRIPPE.

℞ Pepsin in scales.....5 ij.
Acid phosphoric dil.....5 iv.
Syr. hypophos. comp.....q. s. 5 iv.
M. Sig.—Teaspoonful three times a day for an adult.

—*The Prescription.*

Periscope.

THERAPEUTICS.

ACTION OF TUBERCULIN IN RABBITS.

Prof. Doenitz, of Berlin, published in November (*Amer. Jour. of Ophthalmology*) the results of experiments in regard to the action of tuberculin upon the experimental eye tuberculosis of the rabbit. The conclusions are:

1. The tuberculin is a sure curative agent for the experimental tuberculosis of the eye of the rabbit.

2. The tuberculin shows its curative effect only after the tubercle can be demonstrated.

3. The first effect of the tuberculin is a transient, but severe irritation of the eye.

4. Under the continuous action of the tuberculin, all irritation of the eye subsides.

5. When, before beginning the treatment, deep-reaching destructive processes have not occurred, the cure results in retention of the visual functions of the eye, otherwise atrophy results.

TREATMENT OF PLEURITIC EFFUSIONS.

Köster (*Therap. Monatsh.*, March, 1892) says that the use of the salicylates in the treatment of serous pleuritic effusions has not become so general as it deserves to be. He has thus treated 32 cases, 27 of which were examples of the primary disease, while 5 were secondary to tubercle, as shown by the physical signs or character of the fluid. In 17 out of the 27 cases the results were very favorable. These cases not only included small as well as recent effusions, but also large ones and those in which the patient had suffered from symptoms for weeks. The results, however, were most favorable in recent cases. In most patients there was moderate fever, which declined rapidly. Absorption began almost as soon as the treatment, and in from five to seven days even large effusions had disappeared. Once or twice the abnormal physical signs did not clear up for some time. The amount of urine was quickly increased. The symptoms of which the patient complained soon disappeared. In 10 out of the 27 cases the results did not differ from those obtained by other methods of treatment, and

3 of these had to be tapped. The probability of the tuberculous nature of these cases must be borne in mind, but here there was no evidence in favor of it. Among the cases of apparently secondary pleurisy, the results were occasionally also decidedly good.—*Brit. Med. Jour.*

MEDICINE.

PARACENTESIS PERICARDII IN GRAVES' DISEASE.

Shattuck (*Boston Med. and Surg. Jour.*, November 5th, 1891) records this case. The patient, a young woman, aged 24, suffered from rheumatic symptoms and pericarditis. The pericardial effusion rapidly increased, so that on the eighth day the area of cardiac dullness extended from well outside the left nipple nearly to the right nipple and up to the second rib. Aspiration was decided upon, so a trocar was introduced into the fifth left interspace three inches from the median line; about one ounce of bloody serous fluid was removed. As no more could be obtained from this situation, though the cannula was freely movable, another puncture was made in the fourth right space two and a-half inches from the middle line, but no fluid was obtained. An ice bag was applied to the heart, and next day pericardial friction was heard. Two days later, as she was worse, another puncture was made on the left side, but only half an ounce of blood-stained serum was withdrawn, and two days later another puncture on this side, but further out, failed to remove any fluid. After this the patient did well, and eventually recovered. During convalescence it was discovered that she was the subject of Graves' disease, but without exophthalmos, and it was surmised that this disease had been existent all along.—*Brit. Med. Jour.*

HIGH TEMPERATURE IN INTERMITTENT FEVER.

Dr. Stephen Mackenzie, in the *British Medical Journal* for February 13th, reports a case of intermittent fever in which twice the temperature was 107° F., twice 113°, and once 113-8°. The observations were made with the thermometer in one or the other axilla; sometimes two thermometers were placed in the axilla at one time and found to correspond. On account of rigors the temperature could not be taken in the mouth. The periods of hyperpyrexia were exceedingly brief, sometimes a return to normal temperature occurring in five minutes. The patient recovered.

SURGERY.

OPERATIVE TREATMENT OF GLAUCOMA.

Collins (*R. L. Oph. Hosp. Reports*, Dec., 1891,) gives some interesting conclusions based upon the pathological examination of twenty-three eyeballs which had been operated upon for glaucoma, chiefly by iridectomy. Assuming that the tension in primary glaucoma, however it may arise, is kept up by the apposition of the root of the iris to the posterior surface of the cornea and a consequent blocking of the filtration angle, Collins infers that an iridectomy may remedy the condition in either of three ways:

1. When the apposition is recent, very slight means may suffice for the escape of the aqueous, a drag on the iris being often enough to loosen the attachment.

2. In recent or acute cases the iris may tear away from its extreme root, thus leaving a portion of the filtration area free for drainage, even should the remainder of the iris keep its faulty position.

3. In other cases a permanent gap is maintained in the walls of the globe by the prolapse of a fold of iris into the wound. Subsequent stretching or atrophy of the iris tissue occurs, or periodic rupture of the same, thus allowing the aqueous to pass through into the subjunctival tissue and thus become absorbed.

A sclerotomy may produce a permanent reduction of tension in either the first or last of these ways, or it may open up a fresh means of access to the filtration area, so that excess of fluid could find a direct channel of exit from the posterior channel. It is unlikely that the fibrous tissue of a cicatrix should more easily allow filtration through it than the ordinary tissue of sclera or cornea. Iridectomy or sclerotomy will fail to relieve tension when none of the above results are attained. An iridectomy may also fail in consequence of displacement forward of the lens, so that its upper part blocks the freshly-opened filtration area, adhesions resulting between

it and the sclero-corneal cicatrix. The practical lesson is the advisability of an early iridectomy before the apposition of the root of the iris has resulted in adhesion, or a preventive iridectomy might be done, as in the majority of cases primary glaucoma affects both eyes. Iridectomy is most likely to succeed where there is least adhesion of iris root and cornea.

OBSTETRICS.

PREGNANCY AND VENTRO-FIXATION.

Fraipont (*Annal. de la Soc. Méd.-chir. de Liège*, 1892, No 4) reports seven cases of ventro-fixation by Winiwarter and himself, three of the patients who were married, becoming pregnant soon after operation, although one of these had a small ovarian cyst and two a cystic ovary. In each instance the diseased ovary was removed and the fundus uteri was attached by deep sutures including the edges of the abdominal wound. One woman was delivered at term, another at seven and one-half months, in consequence of an accident, the child living; the third bore a living child at the eighth month. All the patients complained of severe pains in the cicatrix between the third and fourth months of pregnancy, which were absent in the latter half. Labor was normal in each instance. In one case only the uterus was found to be retroverted after delivery. It is doubtless desirable that pregnancy should not occur so soon after the operation, since the adhesion is at first quite firm, but later becomes more cord-like and distensible, allowing the uterus to rise out of the pelvis, while preserving its normal position.—*Amer. Jour. Med. Sci.*

AN UNUSUAL CASE OF TWINS.

O'Reilly (*Archives of Gynæcology, Obstetrics and Pediatrics*, April, 1892), describes an interesting case of dual pregnancy. The patient, a IV-para, in labor at term, had not felt the movements of her child for ten days. She was delivered of an eight months' macerated fœtus. On attempting delivery by expression O'Reilly noticed that the uterus was larger than usual after delivery and of irregular contour. By vaginal examination nothing abnormal could be detected. Ergot was administered, the pains soon became stronger, another child presented and was delivered living. The mother made a good recovery. There was but one placenta. The cords were attached within a short distance of each other. The placenta for two-thirds of its extent was of a livid red color and firm consistence. To this was attached the cord of the dead child. The other third was separated by a distinct line of demarkation and healthy. The children were not weighed immediately after birth. The living child weighed three pounds one ounce twenty-one days after delivery. The dead child's estimated weight was between four and five pounds. —*Univ. Med. Mag.*

GYNECOLOGY.

THE INFLUENCE OF PELVIC DISEASES ON THE VOICE.

Klein (*Journ. Am. Med. Assoc.*, 1892, No. 16) says that during menstruation women are prone to inflammation of the tonsils and larynx, and that he has observed in singers at this time that the voice often becomes hoarse and deep, assuming a masculine tone, so that one who is accustomed to noting the difference can tell when they are menstruating.

In many cases of ovarian disease he has observed hypertrophy of the tonsils and uvula; as in eunuchs, there appears to be an intimate relation between the voice and the sexual organs.—*Amer. Journ. Med. Sci.*

EXPLORATORY INCISIONS THROUGH VAGINA.

Segond (*Ann. de Gynèc.*, March, 1892) attended a woman, aged 35, whom he believed to be suffering from retroversion, with fibroma of the fundus. Reduction was easy. He made an exploratory incision through the vagina, and found that the tumor was not a fibroma, but an extra-uterine fœtal sac in the right tube. As the opposite tube was diseased Segond removed it, together with the sac and the uterus. A vaginal incision is not, in his opinion, inconvenient should diagnosis prove incorrect. On one occasion he diagnosed a uterine fibroid, made a vaginal incision, and found that the growth was an ovarian cyst; the tumor was removed with ease. In a second case he suspected pelvic abscess; he opened not a pus sac but a

hæmatocele. This was washed and drained, and the patient recovered with perfect internal organs. In a third pelvic fibroma was diagnosed. On vaginal incision he found a mass of proliferous ovarian tumors, and removed them, together with the uterus through the vagina. The tumor had been treated by electricity for eighteen months. When a large swelling projects downwards, pushing the vagina in front of it, the operation should be done through the vagina.—*Brit. Med. Jour.*

PEDIATRICS.

GONORRHŒAL RHEUMATISM IN THE INFANT.

Dr. Beclère has just called attention, in the *Revue dè Gènéral de Clinique et de Thérapeutique*, to a complication of gonorrhœa little known about till now, gonorrhœal rheumatism in youthful age. In less than a year he has observed two cases, one in a little girl of five and a-half years, the other in a still younger subject, a baby of twenty months. In the first of these little patients the origin of the contagion could be definitely established; the child had been the victim of an apprentice of sixteen or seventeen years of age, who had a gonorrhœa of some standing. The child was treated by immobilization and compression with cotton, and was cured in fifteen days of its arthritis, but it preserved for some time a certain amount of muscular atrophy of the whole left upper extremity (arthritis located in the left wrist), which gave way to continuous currents; the vulvo-vaginitis disappeared after lotions and injections of bichloride. Thus, in the first case, nothing is plainer; the child was contaminated by a subject of the disease, had a blenorrhagia of which the origin was known, followed by a rheumatism of the wrist. It was not the same in the author's second case; here there was a twenty months' old infant presenting the right tibio-tarsal articulation in a swollen, rosy, painful condition, together with a thick, purulent vaginal discharge and a drop of pus exuding from the meatus-urinarius. It was impossible to get precise data concerning the origin of this running, but the aunt of the infant acknowledged that the little girl slept with her mother, who had for several months suffered from a greenish vaginal discharge. The mother could not be examined. The author thinks that in this case we have to deal with a gonorrhœa-insontium accidentally transmitted by the mother to the daughter. These cases, we repeat, should call the attention of practitioners to the fact that, when they observe in infants of a tender age articular manifestations having the clinical aspect of gonorrhœal rheumatism, age does not constitute a sufficient argument to make us reject the diagnosis. On the contrary, such a case should make us think of this possibility, and cause us to make a thorough examination of the genital organs.

HYGIENE.

DOES INFLUENZA PROTECT FROM A SUBSEQUENT ATTACK?

The question whether an attack of influenza confers protection from subsequent infection is one which must have often arisen during the experiences of the last three years, but the data for its solution are not yet fully available. The amount of information which must have been gleaned by the family practitioner in all parts of the country upon this and many other points concerning the malady would, if collated, go far to settle the matter. It is of course notorious that certain individuals have suffered from more than one attack; but the conviction is pretty general that such cases really form but a small minority of the large numbers who have suffered. Then, again, it must be deemed possibly that the degree and duration of the protection may depend on the severity which the primary attack exhibited, for one can hardly invoke the doctrine of attenuation of virus in the case of this disease, which shows so much variation from the ordinary course of infective disorders in general. In a highly interesting contribution upon the features of the present epidemic in Berlin, Dr. Ruhemann directs especial attention to this question of protection and affords valuable evidence of it. He aptly remarks that the more gradual evolution and persistent character of the present epidemic, as compared with the rapid and stormy course of the pandemic of 1889 to 1890, have afforded opportunity for more closely studying the character of the malady, and that it has especially enabled us to recognize more clearly its con-

tagious nature. According to him influenza has prevailed in Berlin ever since the beginning of last September, and he notes how on this occasion the stress of the outbreak had fallen to a far greater extent upon women and children and less upon men than was the case two years ago. His own practice affords proof of this, especially in the fact of the greater frequency of uncomplicated cases among women than among men. As to the question of protection, he has observed that members of families who were severely attacked two years ago have either escaped entirely at present or been only slightly affected; whilst, conversely, the most serious cases of the present time have arisen in households which the influenza spared during its earlier visitation. He notes the statement of Dr. Edw. Gray, to the effect that "many persons who escaped the epidemic of 1775 were affected by that of 1782, and many who escaped the latter were affected by the former," as showing that a century ago this question of immunity had not passed unnoticed. Dr. Ruhemann gives his experience of 55 families, numbering 193 individuals. In 1889–90 there were 64 cases of influenza among this group, whilst in the present outbreak only 40 have been attacked, and, what is of special interest, only 5 out of this number were affected (and that but slightly) two years ago, whilst of the 64 then attacked, only 4 have again become victims. Should this prove to be anything like the general experience it would go far to substantiate a fact that has hitherto been much disputed, even to the extent of declaring that one attack predisposes to another. That one individual may have several recurrences during the prevalence of a single epidemic does not, in Dr. Ruhemann's opinion, mitigate against the general doctrine of protection, since he thinks many such recurrences may be explained by lack of caution on the part of the patients against exposing themselves to fresh infection before they are restored to full health. That influenza does not protect from a second infection should reassure many persons who, having once suffered severely from it, dread a repetition of so depressing a malady, and it may be further comfort to them to learn that the more they have to suffer at first, the less likely are they to suffer at all again. If, then, influenza shares this common property of all infective diseases, it is not so remarkable that it should not apparently select the young in preference to the adult and aged, seeing that the whole community is more or less "unprotected" when it first reappears after an absence (in pandemic form) of years.—*Lancet.*

MEDICAL CHEMISTRY.

CREASOTE AND ITS ELEMENTS.

Dr. E. Main has made a laboratory study of this remedy, which has of late attracted so much attention. He established the fact that the elements of creasote were poisonous in the following order; 1, para-cresylol (least); 2, phlorol; 3, guaiacol; 4, creasote; 5, creasol (most). Locally, creasol was the most irritant, guaiscol the least. For all these elements this laboratory work shows three important characteristics: 1, that they are feebly poisonous; 2, a tolerance can be established; 3, they are eliminated by the lungs. As remedies against tuberculous they can be arranged in the following order: 1 and 2, phlorol and creasol; 3, para-cresylol 4, guaiacol; 5, creasote (most powerful). It is believed that although all the elements of creasote have some value, and indeed guaiacol should be especially mentioned, yet creasote is the most active. Beechwood creasote should be preferred for its antiseptic power, for its feeble toxicity, and because of the results furnished by experimental therapeutics as well as by clinical observation.—*Bulletin Générale de Thérapeutique*, 1892, liv. 10e, p. 205.

ON THE TOXIC AND BACTERICIDE ACTION OF THE SERUM OF THE BLOOD OF THE INSANE.

D'Abundo found that the blood serum of a paranoiac (tranquil) more nearly approached that of a sane individual in its toxic power than any other. During an intercurrent period of depression the toxic action was diminished, while during an excited period it was increased. In quiet melancholia the toxic power was diminished, but prolonged agitation increased it. In quiet dementia it was found constantly lessened. In progressive paresis it increased excepting in two cases, in one of which the patient was in a condition of quiet, and in the other there was a pre-

dominance of motor symptoms. In simple mania and in maniacal exaltation the toxicity is increased. After post-epileptic attacks, and especially in conditions of stupor, it was found diminished. In pellagrous dements it was found notably diminished. In imbecility it was diminished, and in idiocy the results were discrepant. As regards the bactericide action it was found generally increased in insanity and especially in paresis and in mania. It was diminished in post-epileptic conditions and in depressive forms.—*Archivio Italiano per le Malatie Nervose*, Sept., 1891.

NEWS AND MISCELLANY.

A NEW CREMATORY FOR BERLIN.

Berlin is shortly to have a crematory, erected at the city's cost, in the Friedrichsfeld Cemetery, where bodies of the poor and unknown and of the subjects of anatomical investigation at clinics and hospitals will be reduced to ashes. The bodies from the anatomists' tables alone number about 1,000 annually. To further this practice the Berlin Society for Cremation has petitioned the Parliamentary Commission on the Civil Code that the choice between burial and burning be granted hereafter to every German citizen.

INFLUENZA AND DRUGS.

It is stated that quinine, which in 1878 was selling at 16s. per ounce, is now selling at 10½d. The price of eucalyptus oil has suddenly doubled owing to the popular demand for it as an agreeable diffusible aromatic, vaguely supposed to have antiseptic properties when diffused in the air. To be of any use whatever—except as a mental consolation and encouragement—it would need to be used in quantities which would make the air irrespirable. Innumerable "specifics" continue to be irrationally puffed—salicin, salicylate of soda, bicarbonate of potass, antipyrine, salipyrin, and of course also hydropathy and quack remedies innumerable. It is surprising that educated men should be willing thus to enter the lists of public notoriety by recommending specific drugs for a disease which is not known to admit of any, and that they should endeavor to press upon an uninstructed public incapable of forming a correct judgment a universal use of drugs and therapeutic methods which can only be correctly used or estimated by qualified medical attendants, capable of judging the particular needs and the clinical condition of each patient. There is some loss of professional self-respect involved in such proceedings, and no good can accrue to the general public, who can but be bewildered, and are very likely to be dangerously misled by such a course.—*Brit. Med. Jour.*

AGAINST PROPRIETARY MEDICINES.

At the meeting of the Missouri State Medical Association, Dr. L. Bremer, of St. Louis, Mo., introduced the following resolutions which were unanimously adopted:

Whereas, The evil of prescribing and recommending proprietary medicines is constantly increasing, much to the detriment of the profession and the public, especially the latter, many of whom are led into the drug-habit; therefore,

Be it resolved, by the members of the Missouri State Medical Association, that we condemn the practice on the part of some physicians of giving certificates as to the efficacy or special uses and advantages of proprietary medicines, or what is usually understood by this term.

Resolved, That as a body we recommend to the profession the future discontinuance of such medicines, if now used by them.

HOT SPRINGS, THE DOCTORS, AND THE TOUTERS.

The following circular was adopted by the Hot Springs City Council, March 1892: "Don't listen to any one who volunteers advice about doctors. No regular physician will require more than $5 in advance. If you have letters to a physician, deliver them in person. If drummers find you have such letters, they will tell you the doctor is out of the city, dead, quit practising, drunk, or something of the kind. Drummers on the trains, on the streets, or at the hotels or boarding-houses will pretend that they are visitors."—*Weekly Medical Review.*